Operational Protocols

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Final Operational Protocols for The Primary Care Network of Utah Utah Department of Health Division of Health Care Financing

1.0Administrative Confirmation

The Utah Division of Health Care Financing (DHCF) hereby acknowledges its responsibility to conform to the special terms and conditions (T&C) that accompanied the award letter granting Utah the 1115 waiver allowing the implementation of the Utah Primary Care Network (PCN). The division will provide CMS all documentation and reports required by the special terms and conditions, and any other materials requested by CMS during the duration of the demonstration. If the division desires to make subsequent changes in the demonstration that are the result of major changes in policy or operating procedures, the division will submit those changes to CMS in accordance with item numbers IV(3) and VIII(2) of the terms and conditions.

2.0Overview[1]

In the first few months after beginning his first term in 1993, Governor Leavitt introduced *HealthPrint*, a step-by-step incremental plan for reducing the uninsured rates in Utah. Under *HealthPrint's* careful design, the Leavitt Administration has implemented access initiatives targeted at specific populations to increase coverage for children, seniors, and the disabled.

One of these initiatives was the highly successful Children's Health Insurance Program [CHIP] which offered benefits similar to that of the Utah Public Employees Plan rather than the more generous Medicaid design. CHIP had become so successful in reaching uninsured children that its enrollment surpassed available

[1]Extracted from a paper written by Rod Betit, Executive Director, Utah Department of Health; February 9, 2002.

funding and program enrollment was suspended in January 2002 pending additional funding.

These initiatives have contributed to Utah seeing the lowest uninsured rates for some time. The overall uninsured rate in Utah as of February 2002 is approximately 9% and is even lower for children at approximately 7.3%. [The children's rate could be as high as 11% without CHIP.]

With these successful initiatives to build upon, it is now time to address health care access for low-income working adults who have no health care coverage at all. These Utahns may be working 2 or 3 part-time jobs and do not qualify for paid health care coverage through their employer, or may hold a full time job in a company that cannot afford to provide their workforce with health care coverage, or may have seasonal employment and go without health care coverage on the off-season.

Within the 9% of Utahns who remain uninsured, approximately 152,000 individuals are between the ages of 18 and 64, and most are working. This new waiver will allow the state to reach approximately 25,000 of these individuals, whose income is below 150% of the federal poverty level, with a limited health care benefit. This limited benefit will provide these individuals ongoing access to primary care, pharmacy and emergency coverage among other benefits. This Waiver program will reduce the number of uninsured in this age group by over 16%.

States cannot continue to expand full Medicaid coverage to the remaining uninsured as that model is too costly, covers too few people, and encourages "crowd out", the phenomenon where people already insured in the workplace migrate to public coverage resulting in no reduction in the number of uninsured. There is considerable evidence that those states that have simply expanded full Medicaid coverage to adults have spent a great deal of state funds, but have not had the impact on the uninsured rates in their state that they had expected.

Utah's philosophy under this new Waiver is that offering some coverage to these low-income working adults until their income allows them to afford more complete

coverage, or they become employed in a company that pays for a bigger share of their health care coverage, is far better than providing no coverage at all. We believe that the "one size fits all" approach of federal Medicaid rules fails to recognize the complexity of issues that arise as you attempt to cover more of the low income working population, without creating unwanted consequences like "crowd out".

Any adult between the age of 19-64 who has not had health care coverage for at least 6 months, whose employer pays less than 50% of their health care benefit, and whose annual income is less that 150% of the federal poverty level can be covered under this program. Adults do not have to be parents to qualify.

Since this is a demonstration program, enrollment will be limited to 25,000 adults until program evaluations can be completed on how successful this limited benefit plan is in reducing health problems for this population, in reducing the use of emergency rooms and hospital admissions, and its effectiveness in providing some medical coverage to the uninsured without causing crowd out.

The Waiver will provide primary and preventive care plus some emergency coverage. The benefit plan includes primary care physician office visits, flu immunizations, urgent care visits, emergency room visits, lab, x-ray, ambulance transport, medical equipment, medical supplies, oxygen, vision screening but not eyeglasses, and prescription drugs.

Non-covered services include out-patient hospital; in-patient hospital; out-patient and in-patient specialty physician care; non-emergency transportation to medical care by public transit or taxi; dental care like orthodontia, root canals, and crowns; mental health treatment; substance abuse treatment; physical therapy; occupational therapy; and chiropractic care.

There will be an annual enrollment fee plus co-payments similar to those required by enrollees in the CHIP program. There will be a $1000 annual out-of-pocket maximum per enrollee.

Approximately 17,600 adults who are parents of children on Medicaid, or who are receiving both Medicaid and TANF assistance will see reduced coverage. It is important to note that even after these reductions, coverage will still be comprehensive, very much like that offered under the Children's Health Insurance Plan and comparable to most employer sponsored plans. Benefits for children, the physically disabled, the chronically mentally ill, persons 65 and older, pregnant women, and women with breast or cervical cancer will not be affected.

3.0 Protocols

3.1 Current Organization of the Department of Health

The Utah Department of Health (UDOH) is composed of different divisions and offices responsible for overseeing public health and health system issues in the state. Some of the major organizational units of the department are: (An organizational chart of the department is provided in Attachment A.)

3.1.1. Division of Community and Family Health Services

3.1.2. Division of Health Care Financing

3.1.3. Division of Health Systems Improvement

3.1.4. Division of Epidemiology and Laboratory Services

3.1.5. Office of Public Health Assessment

3.1.6. Office of the State Medical Examiner

3.1.7. Children's Health Insurance Program

3.2 Current Organization and Structural Administration of the Division of Health

Care Finance

The Division of Health Care Financing administers the state Medicaid program under the rules and regulations of Title XIX of the Social Security Act and is responsible for the Medicaid program planning and policy development, contract administration, and quality assurance functions. The division will administer the 1115 waiver demonstration program. The division is organized in nine branches: five bureaus, one office, and three units, as follows. (Organizational charts of the division and bureaus are provided in Attachment B.)

3.2.1. Office of the Director (OD). The Office of the Director is responsible for administering and coordinating the program responsibilities delegated to staff in order to develop Utah's Medicaid program in compliance with Title XIX of the Social Security Act, the laws of the state of Utah, and the appropriated budget.

3.2.2. Bureau of Coverage, Reimbursement Policy and Utilization Management (BCPR). This bureau makes recommendations to the division director dealing with scope of services and payment methodologies for services, with special emphasis on negotiating actuarially sound capitation rates. Further, the bureau is responsible for the utilization management of the Utah Medicaid program.

3.2.3. Bureau of Eligibility Services (BES). Eligibility Services is responsible for determining the Medicaid eligibility policies and field operations related to the determination of Medicaid eligibility.

The BES is responsible for coordinating and overseeing the eligibility contract with the Department of Workforce Services (TANF Agency) and providing coordinating with the Office of Recovery Services IV-D Agency.

3.2.4. Bureau of Financial Services (BFS). Financial Services provides three main functions within the division:

a) manages the administration and service budgets for both the Medicaid and UMAP programs;

b) monitors the drug rebate program within the state;

c) performs audits on Medicaid providers within the state to cost settle Medicaid rates reimbursements and performs cost studies on reimbursement rates to evaluate if fair rates are being set for provider services; and

3.2.5. Bureau of Managed Health Care (BMHC). Managed Health Care is the operational arm of the Freedom of Choice Waivers and has responsibility for the implementation and operation of the managed care initiatives that includes contracting with health maintenance organizations (HMOs) and Prepaid Mental Health Plans (community mental health centers) to serve the medical and mental health needs of Medicaid clients. The bureau is responsible for the development and operation of Medicaid specialized services for special populations, the operation of children's HCBS waivers and the school based services program.

3.2.6. Bureau of Medicaid Claims Processing (BMCP). This bureau ensures that:

a) providers are informed and trained in Medicaid policy and procedures;

b) claims are paid accurately and timely; and

c) supporting computer data bases, e.g., MMIS, are current and accurate.

3.2.7. Information Technology Unit (ITU). The Information Technology Unit is responsible for the development, operation and maintenance of the Medicaid Management Information System (MMIS). The unit also provides support for information analysis needs of the division as well as other data processing needs.

3.2.8. Long Term Care Unit (LTCU). The Long Term Care Unit is responsible for policy development in the area of both institutional and community-based service programs. The unit also provides contract support and oversight of home and community-based service waivers where the daily administration has been delegated to the Department of Human Services.

3.2.9. Research and Analysis Unit (R&A). The Research and Analysis Unit is located in the Office of the Director and provides program research, evaluation and analysis support. The Medicaid Eligibility Quality Control and the CPAS and SPR functions are housed within this unit.

3.3 Organization and Structural Administration of the Demonstration Project[2]

The PCN Demonstration Project will be supported by the Utah Department of Health through its Division of Health Care Financing under the direction of the Executive Director of the Department of Health.

3.3.1. Office of the Director. The OD will be responsible for administering and coordinating the project responsibilities delegated to staff and will determine eligibility policy for participation in Utah's PCN.

3.3.1.1Research and Analysis Unit. Working in concert with the Office of Public Health Assessment, the R&A will be responsible for ensuring all required data for evaluating the results of Utah's

[2]See Attachment C for a cross reference to the naming conventions used in discussions, the waiver application and the *Terms and Conditions.*

demonstration project are obtained and are accurate, and for maintaining that data; coordinating and participating in the evaluation activities of the demonstration project; and coordinating and participating in the reporting functions.

3.3.2. Bureau of Coverage, Reimbursement Policy and Utilization Management. The BCPR will be responsible for making recommendations to the division director dealing with scope of services and payment methodologies for services and benefits delivered to clients under the demonstration project, and will be responsible for the utilization management of the PCN.

3.3.3. Bureau of Eligibility Services. The BES will be responsible for determining the PCN eligibility policies and field operations related to the determination of PCN eligibility.

The bureau will be responsible for educating individuals whose eligibility is established at out-station sites for the demonstration project and addressing enrollee problems. Questions from the clients related to eligibility will continue to be handled by the unit.

The BES will be responsible for coordinating and overseeing the eligibility contract with the Department of Workforce Services (TANF agency) and providing coordinating with the Office of Recovery Services IV-D agency.

3.3.4. Bureau of Financial Services. The BFS will be responsible for monitoring PCN expenditures and ensuring close adherence to the negotiated cost neutrality requirements of the project. It will be responsible for monitoring enrollment and enrollment caps, in addition to providing all required financial reporting.

3.3.5. Bureau of Managed Health Care. The BMHC will be responsible for ensuring the adequacy of the provider network. The bureau will

ensure that all TANF adult eligibles in urban areas are enrolled in an HMO and will be responsible for negotiating, executing and monitoring any contracts necessary to accomplish this task. Monitoring functions will include quality assurance, grievance and problem resolution, client and provider satisfaction, and for directing and conducting the quality assurance activities of the PCN.

3.3.6. Bureau of Medicaid Claims Processing. The BMCP will ensure that providers are informed and trained in the new PCN procedures, that PCN claims are paid accurately and timely, and will provided support for the PCN computer data bases ensuring their accuracy and currency.

3.3.7. Information Technology Unit. The ITU will be responsible for the development, operation and maintenance of the new PCN components to the Medicaid Management Information System (MMIS). The unit will also provide support for analytic information needs of the PCN.

3.3.8. The DOH Office of Health Care Statistics (OHCS) will provide additional assistance to the division in the essential analysis of data for the evaluation portion of the waiver project and for conducting any utilization and health status surveys.

3.4 Project Reporting

The state agrees with the reporting requirements contained in item III of the waiver terms and conditions. The DHCF will submit to CMS quarterly progress reports no later than 60 days after the end of the reporting period, the first being due by November 30, 2002. Reports will contain all relevant information on the state's progress in implementing the PCN and will include any operational and policy issues appropriate to the project design. As required by the T&C the state will furnish enrollment information, and information on the project disenrollments, giving the reasons for disenrollment.

Item 3(a) of Attachment A of the T&C requires the submission of quarterly data on the actual number of eligible member months for the Medicaid eligibility groups (MEG) defined as:

> "The first MEG will be 'Current Eligibles,' and will be comprised of (sic) current eligibles as defined in Section II.2.b of the Special Terms and Conditions."
>
> "The second MEG will be the hypothetical '1092(r)(2) eligibles. These are members of the Demonstration population I as defined in Section II.2.c of the special Terms and Conditions who could be eligible for Medicaid under Section 1931 if the state further liberalized its eligibility criteria in its state plan. [The MEG]'1902(r)(2) eligibles does not include members of Demonstration Population I who are childless adults, nor members of Demonstration Population II."

The state will furnish these data in the overall quarterly report. The state will also report quarterly on the member months for:

a) high-risk pregnant women (Demonstration Population II); and

b) childless adults in the PCN population.

Additionally, the state will include the results of to-date evaluation activities, and the November 30, 2002 quarterly report will include the resulting collection of the following baseline data:

a) current Utah Medical Assistance Program (UMAP) utilization patterns including specialty, donated services;

b) current utilization patterns for 1931 TANF adults, medically needy and transitional Medicaid; and

c) current utilization and reimbursement patterns for FQHCs and local health

clinics.

Finally, the state will submit to CMS an annual report no later than 6 months after the end of each operational year.

3.5 Income Limits

The following is a description of the income limits to be used for the new PCN group of eligibles:

3.5.1 Income Limit. To be income eligible for the PCN, the person's countable income must be less than 150% of the Federal Poverty Level (FPL) for the applicable household size.

3.5.2 Countable Income. The countable income is all earned and unearned income received by the applicant and his or her spouse, minus any income exclusions. A best estimate of all countable income expected to be received over the 12 month certification period shall be made based on the applicant's current and past circumstances and reasonable expectations of future circumstances. Income paid weekly or every two weeks will be factored to determine the monthly total.

3.5.2.1 Determination of Income Eligibility. Income eligibility for the PCN will be determined by prospectively "best estimating" all income expected to be received over the 12 month certification period. The best estimate of income will be based on the applicant's reasonable expectations and knowledge of current, past, and expected future circumstances. In determining the best estimate of income the eligibility worker will use the techniques of anticipating, averaging or annualizing income to determine an appropriate monthly amounts. Income that is paid weekly or every two weeks must be factored.

a) Income that was received prior to the month of application will not be counted.
b) Income that has terminated even if the applicant will receive the last payment after the date of application will not be counted.
c) Income received less often than monthly will be averaged over a 12 month certification period to determine a monthly amount.
d) Income received sporadically or under contract or commission or received at irregular intervals throughout the year will be annualized.

The method used to determine the best estimate is based upon the type of income, the frequency of receipt of income, the individual's earning history and any anticipated changes in circumstances. The eligibility worker will determine which method to use based upon the applicant's history and current circumstances.

The total of all income expected to be received over the 12 month certification period will be reduced to a monthly amount and compared to 150% of the poverty level for the household size. If the countable income is equal to or less than the income limit for the household size, the applicant meets the income eligibility requirement.

3.5.2.2Income Determination Documentation. The methods used in determining the best estimate, the calculations and the amounts agreed upon between the applicant and the eligibility worker must be clearly documented. If anticipated income changes were considered in the best estimate determination, these changes should also be clearly documented

3.5.3 Income Exclusions. The same income exclusions apply to this program as for other Medicaid programs, with two exceptions. The exceptions are:

a) SSI income of a spouse will be counted, and
b) the income of any person under age 19 will be excluded, unless they are the head of the household.

3.5.4 Income Deductions. No income deductions or disregards will be allowed.

3.5.5 Spenddown. No spenddown is allowed.

3.5.6 Household Size. Spouses and dependent children under age 19 who live together will be counted in the household size to determine the income limit.

3.5.7 Assets. There is no asset limit in determining eligibility for the PCN. However, eligibility workers may need to ask about assets to determine if the applicant would be eligible for a Medicaid program..

3.6 Eligibility

3.6.1 Eligibility Determination. Eligibility for all demonstration populations will be done through the BES and may be also done through the Department of Workforce Services (DWS) for those applying for General Assistance, Food Stamps and 1931 TANF families.

3.6.2 Eligibility Process. Individuals or households who want medical assistance must submit an application in order to receive benefits from any medical assistance program for which they may be eligible.

3.6.2.1 Application. An application for medical assistance may be submitted in person, by mail or by fax to a local DWS office or a BES office or outreach location.

An applicant must apply for assistance in his own behalf unless he is unable to do so because of incapacity which prevents him from completing the application process. If the applicant requests help to complete the forms, the local supervisor shall assign someone to assist him

Any interview or discussion about the application may be in-person, on the telephone, or by mail. The eligibility worker determines an individual's eligibility for assistance by applying the program income standard, as found in the policy manuals, to the individual's circumstances. Also, they will establish the validity and accuracy of the information given by the applicant. In lieu of discussion with the applicant, the worker may interview the person's authorized representative. The worker does not require the applicant to come to any office. The date of application is the date a completed and signed application is received by a local DWS or BES office or outreach location.

3.6.2.2Rights and Responsibilities. All applicants are informed of his or her responsibilities and rights, including:

a) the eligibility requirements of the medical program;
b) the time periods to decide eligibility;
c) the right to a fair hearing;
d) how to request a hearing; and
e) the right to use legal counsel at the hearing.

3.6.2.3Eligibility is Determined. A verbal description of what and why the eligibility worker does what he does is noted in the electronic case file. The applicant is approved for whichever Medicaid program is most beneficial to them, if criteria are met. Staff is routinely trained about the differences in the various Medicaid programs, and on the importance of approving the applicant for the program that is the most beneficial.

In addition to determining eligibility, eligibility workers explain to the client exactly what they have been approved for, what the

program benefits are, and how to access these benefits.

A written notice is sent to the applicant, notifying them of the decision, explaining the reason for any adverse action, and explaining what their appeal rights are.

3.6.2.4Eligibility Redetermination. All factors of eligibility must be reviewed every 12 months. PCN eligibles will also be screened for Medicaid eligibility during each eligibility redetermination process.

A review form is automatically mailed to the household in the month immediately proceeding the review month. The household may complete and return the review form or contact the worker to complete the review over the phone. Information about the household that is currently in the eligibility determination system will be printed on the review form that is mailed to the household. The household is instructed to make any corrections to the information and return the form or contact the worker.

The household is given at least 10 days to provide the verification.

3.6.2.5Eligibility Redetermination is Made. A verbal description of what and why the eligibility worker does what he does is noted in the electronic case file. The applicant is approved for whichever Medicaid program is most beneficial to them, if criteria are met.

A written notice is sent to the household, notifying them of the decision, and explaining the reason for any adverse action, and explaining what their appeal rights are.

3.6.3 Eligibility for Non-Traditional Medicaid. This plan requires a reduced benefit plan for some current eligibles that previously received full benefits under the Medicaid State Plan. Those eligible for benefits and services under this part of the section 1115 demonstration will include 1931 TANF adults, the medically needy and those eligible for Transitional Medicaid. If a beneficiary under this plan becomes pregnant, she will be eligible for services under the Traditional Medicaid plan. Identification of these women must be by self-reporting, and they will be educated through the standard educational materials on the need to report pregnancies

3.6.4 Eligibility for PCN is defined as individuals age 19 and above with incomes under 150 % the federal poverty level who are not otherwise eligible for Medicaid through the state plan, and who are only covered under Medicaid through the section 1115 demonstration.

The division will use the Public Assistance Case Management Information System (PACMIS) to identify the two sub groups of PCN eligibles, adults with children and childless adults. Children will be entered into the system and it will be programmed to count those adults with children and those without children.

A summary report will be generated from PACMIS that will give us separate point in time and cumulative counts of PCN childless adults and PCN adults with children. The data will include the number of applications registered, the number approved, and the number denied. See 3.8 below.

This information will be used to project the future point at which applications will no longer be taken; so that the enrollment cap will not be exceeded.

3.6.4.1PCN Non-Eligibles. Individuals who have health insurance or

have access to health insurance coverage are not eligible for the PCN. The following persons would not qualify for the PCN:

a) a person who is enrolled under a group health plan or other health insurance coverage through which they have not exhausted their maximum lifetime benefits;

b) a person who is enrolled in, or is eligible for Medicare;

. c) a person who is enrolled in, or is eligible for the Veteran's Administration Health Care System;

d) an employed person or spouse of an employed person who has access to health insurance coverage available through an employer where the employer pays 50% or more of the cost for the individual and/or the spouse to enroll in the plan;

e) a person who is a full-time student or the spouse of a full time student who has access to health insurance coverage that is available through the educational facility where the cost to enroll is less than 5% of the household's gross countable income;

3.6.4.2Termination of Health Insurance Coverage.

3.6.4.2.1Voluntary Termination of Coverage. A person is not eligible for the PCN if he or she has voluntarily terminated coverage of any health insurance plan (except COBRA coverage), within 181 days before

applying for the PCN. The person may be eligible beginning the 182nd day after the date the prior insurance coverage ended.
Exceptions to 181 day ineligibility period:

a) voluntary termination of COBRA coverage;

b) voluntary termination of coverage by a parent; and

c) voluntary termination of coverage by a spouse who is not living in the same household as the applicant.

3.6.4.2.2Involuntary Termination of Coverage. An applicant who is involuntarily terminated from a group health plan may be eligible for the PCN with no ineligibility period. For example, the employer terminates the group health plan for all of its employees.

If an applicant has been terminated from a job, or has quit a job, and loses health insurance coverage as a result, the loss of the health insurance is an involuntary termination. The applicant is not required to purchase any available COBRA coverage.

3.6.4.3Dates of Coverage; Eligible Spouse; Re-application; Re-opening; Certification; Reportable Changes; and Re-certification: See Attachment D from revised Eligibility Manual.

3.6.4.4Transition of Current UMAP Eligibles to PCN.

a) On June 5, 2002, current UMAP clients will be mailed a notice explaining that UMAP ends on June 30 and

PCN starts on July1. That notice will explain the PCN scope of service and the process UMAP clients use for PCN eligibility determinations.

b) On about June 15, UMAP closure notices will be mailed to UMAP clients. The closure notices will tell the UMAP clients how to make contact if they are interested in applying for the PCN. The closure notice will also tell the UMAP clients that they will receive a brief questionnaire in a separate envelope.

c) On about June 15, a questionnaire will be mailed to all UMAP clients. The questionnaire will have five questions about other health insurance coverage. The questionnaire will instruct the UMAP clients that they can call the BES, mail or fax the questionnaire to indicate their interest in applying for the PCN.

d) In response to this contact, the BES will use information in the UMAP case file and the information about health insurance coverage to determine PCN eligibility.

e) If the UMAP clients are eligible for PCN, they will be given the opportunity to pay their enrollment fees so that PCN coverage will begin July 1.

f) If the UMAP clients are not eligible for PCN, we will send an adequate and timely denial notice.

3.6.5 Eligibility for Pregnant Women at Risk (Demonstration Population II) is defined as any pregnant women deemed by the state to be high risk, and who meets all other Medicaid eligibility criteria under SOBRA, and who have assets in excess of the limit established by the state plan. This includes those who are eligible only for emergency services.

Past proof of a high risk has been:

a. a statement from the treating health care provider; or

b. a value of 15 or higher on the UPRS form.

The DHCF has been informed that the form is not used by all providers due to its complexity. For this reason, the DOH is not printing the form in the future. As long as the supply in provider offices last, the DHCF will accept it. The DHCF will continue to accept a statement for the health care provider.

3.6.5.1 Asset Calculation for Pregnant Women. The asset standard for Demonstration Population II is $5,000.00. There is no asset payment if the value of the countable assets is less than $5,000. If the value of the countable assets is $5,000 or more, the worker will multiply the value of the countable assets by 0.04 (4%).

a) The pregnant women must pay this amount or $3,367.00, which ever is less if the pregnancy is not high risk, to be eligible for the Prenatal Program (SOBRA).

b) If the pregnancy is high risk, then the woman is exempt for the asset payment.

3.6.6 Eligibility Verification. All factors of eligibility must be verified, with the goal of making accurate eligibility determinations. If the applicant cannot provide required verification at the time of application, they are given a list of the verifications that are needed (Form 124). The applicant is informed that he must return the necessary verifications within thirty days. Interaction with the client is stressed, and following up on questionable information is required. There are five types of verification:

a) Computer Interface. Using information available through online systems is the first choice of verification.

b) Hard Copy. Examples of acceptable hard copy verifications can be found in the Medicaid Manuals, but they are not all-inclusive. Any reasonable verification can be accepted as long as it provides the necessary information.

c) Collateral Contact. Contact with another agency, organization, or individual, by telephone, letter, or in person is acceptable.

d) Prudent Person Concept. Using professional judgment, to accept the client's statement, is an acceptable form of verification.

e) Other. The caseworker will determine what other verifications are acceptable.

Federal Requirements mandate that an individual who is not a US citizen must provide verification of their alien status. One adult in the household must certify that all members who receive Medicaid are U.S. citizens or have been granted legal immigration status by INS. Workers are forbidden to require the client to provide verification if there is an alternate source of verification that can be accessed by the worker.

3.6.7 Outreach. All of the eligibility determination for the PCN will be handled by the BES, with the exception of those who are applying for general assistance, food stamps and 1931 TANF adults which are administered by the DWS (approximately 1000+ cases during any given month). The BES has 16 teams, statewide, that are responsible for eligibility determination. Teams are made up of a supervisor, 1-2 lead workers, and 12-17 eligibility workers. The workers are co-located throughout the state in:

a) offices within the DWS;

b) hospitals;
c) county health departments;

d) medical clinics, including community health centers;
e) schools;
f) a Social Security office;
g) aging services offices;
h) a Boys and Girls club;
i) on Indian reservations; and
j) separate BES offices.

Staff in these various offices will be thoroughly trained about all aspects of eligibility for the demonstration populations.

3.6.7.1 Client Convenience. Clients often have the perception that the eligibility process is a paperwork maze. The division has initiated several processes to improve this perception. The current application is very brief. The division has worked with staff to emphasize the importance making the process of eligibility and enrollment as comfortable as possible for applicants and eligibles. Clients who work do not always have the time to come into an office to apply. Staff are required to offer telephone interviewing, in order to improve access. Staff are educated understand that this is a time savings to them, as well as to clients.

The division selectively hires for Spanish speaking eligibility workers, and also has a well developed system of delivering needed language translation services.

Clients may chose any location in the State to apply for Medicaid, or to have their case maintained.

3.6.7.2 Special Populations. Not all client populations are alike. The division has some projects to address special populations and system access:

a) Elderly clients in housing projects: One worker is

assigned to maintain all eligibility for elderly clients housing project residents in Salt Lake City. The worker visits all of the centers several times a month and no client is ever asked to come into the office. The worker also makes home visits to the housebound as needed in other city locations.

b) TB patients: One worker is assigned to staff the Fourth Street Homeless clinic and the City and County clinic on days when TB patients are seen.

c) Robert Wood Johnson grant proposal: The heart of the proposal is a team of an eligibility worker, a community worker, and a school nurse who will work with families in three to four neighborhood schools. The staff physically will be located at, and work between the school locations. Each member of the team will have a different function. The community worker will go to low income families identified by the school, or neighborhood canvassing and help the families apply for medical assistance with the team's eligibility worker. The school nurse will provide an initial health assessment and link the family with a community health center or other resource to meet the immediate health care needs.

3.6.7.3Bilingual and Interpretive Methods. Utah has a very well developed system of delivering interpretive services to applicants for Medicaid services. Five separate interpretive service for translation services are active. Offices have posters prominently posted which indicate that interpretive

services are available (this message in several languages). Once the needed language has been determined, the person in need of translation is given a wallet size card to carry with them that indicates what that language is. Twenty-seven languages are readily available, but additional languages will be provided as needed. Workers have been trained in the process they must follow in order to arrange for these services. Once the worker is aware of the need for translation services, they contact a contracted provider of interpretive services giving identifying information about the client/eligible person, the contractor number, the language requested, time and date an interpreter is needed, and whether the interpreter can participate over the telephone or in person.

3.6.7.4Media. Posters have been developed that will be prominently displayed in eligibility offices and outreach locations. Brochures have also been developed for disseminating information about the program for prospective applicants. They will also serve as a tool to help explain the program to those who have been approved for the program. All materials will be reviewed and approved by the division director prior to distribution.

3.6.7.5Targeted Geographical Areas. Eligibility staff is located statewide, as indicated above. They will be thoroughly trained about all aspects of eligibility for the demonstration populations.

3.7 Enrollment and Disenrollment

3.7.1 Enrollment. At time of application, applicants will be given information about the PCN program including the eligibility requirements, the scope of services, the co payments, and the enrollment fee. Once it has been determined that an individual or legally married couple

meet the eligibility requirements for enrollment in the PCN, the eligibility worker will notify the applicant that a $50 enrollment fee must be paid before any coverage can be authorized. PCN applicants will not be asked for the enrollment fee any time prior to the time their eligibility has been determined.

Demonstration II population will not be charged an enrollment fee.

a) The enrollment fee must be paid within 30 days of the mailing date of the notice informing the applicant that the enrollment fee must be paid.

b) If the enrollment fee is not paid within the required time frame, the enrollment or re-certification will be denied.

c) One $50 enrollment fee covers an individual or a legally married couple for the full twelve month certification period. When an eligible spouse is added to the PCN coverage during the certification period, the enrollment fee that has already been paid and will cover the spouse until the next regular re-certification.

d) The eligible individual or legally married couple must pay the enrollment fee at the time of the initial enrollment and at each 12 month re-certification.

e) If the fee is paid, the application will receive final approval and a second notice will go out stating that it has been approved. A medical card will be mailed concurrent with the notice.

f) If the fee is not paid, the application will be denied. A written notice will be sent which indicates that the application has been denied for failure to pay the enrollment fee.

g) No portion of the $50 enrollment fee will be refunded if the

PCN case closes before the end of the twelve month certification period.

h) If an enrollee loses PCN eligibility for 30 days or more during any 12 month enrolled period, the individual must re-apply and pay another $50 enrollment fee upon acceptance. A new 12 month eligibility period will be established at that time.

3.7.2 Disenrollment. Once found eligible for the PCN, clients will remain enrolled until:

a) they move out of state;
b) they die;
c) they enter a public institution;
d) they become eligible for another Medicaid program;
e) they are covered by or gain access to a third party insurance;
f) At re-certification, it is determined that their household income exceeds 150% FPL; or
g) The client requests their case be closed.

At disenrollment, a written notice will be sent to the household notifying them that their case is closed and explaining the reason for the closure, and explaining what their appeal rights are.

3.8 Enrollment Cap

The Primary Care Network Application Activity Report (PCNAAR—PACMIS MR 698) will be used to monitor the number of persons enrolling in the PCN. Daily, weekly, or monthly reports may be obtained on demand. A copy of the PCNAAR is contained in Attachment P.

The division will monitor the enrollees to make certain that the cap for the following two groups are not exceeded: new enrollees, and the former UMAP group. The division will keep CMS apprised of any changes in enrollment caps

made necessary by the number of enrollees (or expenditures) through the monthly teleconferences and the quarterly reports.

3.8.1 Waiting Lists. The department does not expect that enrollment caps will be reached prior to the end of the second year. It will not maintain a waiting list after enrollment caps are reached. When enrollment caps are reached, the BES will stop taking applications. Applications will not be held over for a new enrollment period.

When enrollment drops low enough , a new enrollment period will be announced during which time applications will be taken. The PCNAAR, will be used to determine the length of the new open enrollment period.

Reports will also be produced on expenditure data that will be used to monitor the per-member-per-month (PMPM) costs. These costs will then be used to monitor the per-capita cost per person to make certain that waiver-approved cost neutrality is not exceeded.

3.9 Implementation Schedule

Implementation scheduling began immediately after the signing of the PCN waiver by Secretary Thompson on February 8, 2002 and was formalized in writing on February 18th. Chart 1 below provides a listing of specific tasks and the required completion dates necessary to meet the desired July 1, 2002, PCN implementation date. The chart is organized by the DHCF bureaus and gives the responsible party for task completion. It identifies tasks that must be completed prior to the beginning of each task.

A PERT chart diagraming the tasks, their inter-relationships, and the critical paths is provided in Attachment E.

[Note: The numbering in the first column is a reference to the PERT chart, while the number beginning each task name in column 2 refers to an original listing obtained from bureau staff. The black dots (•) preceding several of the tasks

indicates those necessary for the completion of the *Operational Protocols*.]

Chart 1:TASK REFERENCE GUIDE FOR PCN IMPLEMENTATION PERT

Several tasks were added after the set e-mailed out on 3/5. They are shown in italics. For the convenience of scheduling the tasks in the PERT, the numbering was re-ordered in some cases and, therefore, will be slightly off from the listings taken from bureau and unit directors.

PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
Director's Office				
1	*IMPLEMENTATION START UP*			
2	1. Complete a divisional staffing review	3.08.02	Deily	1
3	2. Complete the necessary reorganization	5.31.02	Deily	2
14	•3. Divisional approval of PCN scope of service [op]	3.19.02	Deily	13
16	•4. Divisional approval of pharmacy scope of service [op]	3.19.02	Deily	15
18	•5. Divisional approval of cost sharing policy [op]	3.19.02	Deily	17
27	•6. Divisional approval of PCN eligibility policy [op]	3.19.02	Deily	26
20	•8. Divisional approval of identification of PCN provider network [op]	3.19.02	Deily	19
76	9. Divisional approval of specialty care network and details	5.17.02	Deily	75
23	•10. Divisional approval (Baker's) M'caid, PEHP-based and PCN summary description document [op]	3.19.02	Deily	22
50	*Divisional approval of new rules*	*3.15.02*	*Deily*	*47,48,49*
90	11. Divisional approval of UMAP transition plan	3.29.02	Deily	89

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
7	12. Coordinate the collection of data throughout the life of the waiver demonstration program	7.01.02	Morgan	6
8	13. Coordinate the analysis of the data collected throughout the life of the waiver	7.01.02	Morgan	6
4	•14. Provide a detailed description of the evaluation design for the waiver [op]	3.20.02	Morgan	1
5	15. Refine the evaluation plan for PCN project	6.03.02	Morgan	4
6	16. Implement evaluation plan at start of project	7.01.02	Morgan	5
10	•17. Detail the organizational and structural administration of the waiver [op]	3.19.02	Morgan	9
11	•18. Describe the content and frequency of reporting for the waiver [op]	3.19.02	Morgan	9
12	•20. Write operational protocols document [op]	3.26.02	Morgan	10,11,14,16,18, 20,23,25,27,29, 30,31,32,33,34, 35,36
37	•21. Approval of operational protocols document [op]	3.29.02	Deily/Betit	12
38	•22. Send operational protocols document to CMS [op]	3.29.02	DHCF	37
39	*130. CMS approves operational protocols*	*6.28.02*	*CMS*	*38*
40	23. Obtain baseline data on UMAP usage (e.g., specialty care),1931 TANFs, medically needy, and transitional Medicaids	6.21.02	Morgan	4,12

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
9	•24.Prepare an implementation schedule—PERT [op]	3.08.02	Morgan	1
87	*117. Develop a methodology (WAIVER TRACK) to keep track of each program's participants, enrollment amounts, who didn't pay enrollment fees, services delivered, etc.*	*6.14.02*	*Morgan*	*4*
126	*118. Implement WAIVER TRACK*	*6.28.02*	*Morgan*	*87,125*
Bureau of Coverage, Policy and Reimbursement				
13	•27. Complete PCN scope of service detail and code. [op]	3.19.02	Maxfield	1
41	28. Complete and submit to IT scope of service 495	3.26.02	Maxfield	14
15	•29. Complete pharmacy scope of service detail and code. [op]	3.19.02	Ashley	1
42	30. Complete and submit to IT pharmacy scope of service 495	3.26.02	Ashley	16
17	•31. Complete cost sharing policy and detail [op]	3.19.02	Hawley	1
43	32. Complete and submit to IT cost sharing 495	3.26.02	Hawley	18
47	33. Write new state rules for scope of service	3.08.02	Maxfield	1
48	34. Write new state rules for cost allocation	3.08.02	Hawley	1
53	35. Rules filed	4.01.02	Martin	52
54	36. Rule publication	4.15.02	State	53

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
55	37. Public hearings	4.29.02	Anderson	54
56	38. Amend proposed state rules (made necessary by public comment or public hearings)	5.13.02	Maxfield Ashley Hawley	55
57	39. File amended rules	5.15.02	Martin	56
58	40. Republish amended state rule	6.03.02	State	57
59	41. State rule adoption	7.01.02		58
60	42. Develop notices on scope of services, coordinating with the Bureau of Medicaid Operations, to all providers explaining the 1115 demonstration and providing a detailed explanation of the changes in coverage.	4.12.02	Maxfield	50
61	43. Develop notices on cost-sharing, coordinating with the Bureau of Medicaid Operations, to all providers explaining the 1115 demonstration and providing a detailed explanation of the changes in coverage.	4.12.02	Hawley	50
62	44. Develop notices on eligibility, coordinating with the Bureau of Medicaid Operations, to all providers explaining the 1115 demonstration and providing a detailed explanation of the changes in coverage. [op]	4.12.02	Morris	50
63	45. Print & mail provider notices	4.26.02	Morris	60,61,62
70	46. Determine type of provider manual revisions	3.08.02	Anderson	1
71	47. Develop new provider manuals for	3.29.02	Maxfield	70

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
	PEHP-based program		Morris	
72	48. Develop new provider manuals for PCN program (See Attachment F for draft)	3.22.02	Maxfield Morris	70
19	•49. Identify the new primary care network providers for the PCN eligibles	3.14.02	Welch	24
21	129. Write/transmit to IT provider files 495	3.21.02	Welch,BMO	20
73	50. Enlist the PCN primary care providers	5.16.02	Welch	19
74	51. Coordinate with M'caid Operations to provide training of PCN providers	3.29.02	Welch	71,72
75	52. Identify and develop the specialty care network providers	5.10.02	Welch	1
77	53. Set up a tracking system to monitor donated care.	6.17.02	Welch	76
78	*130. Implement Specialty Care Tracking system*	*6.28.02*	*Welch*	*77*
25	•54. Detail grievance and appeals procedures [op]	3.19.02	Gatzemeier	1
79	55. Develop & print pharmacy scope notices	4.26.02	Ashley/Park e	52
80	56. Identify, notify and educate participating pharmacies	5.17.02	Ashley/Park e	79
81	57. Establish rates for scope of services	4.02.02	Goff/Dunn	16,65
82	58. Complete and submit to IT rate setting 495	4.05.02	Goff	81
22	•59. Develop summary comparison of M'caid, PEHP-based and PCN scope of	3.15.02	Baker	1

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
	services [op]			
85	60. Develop detailed of M'caid, PEHP-based and PCN comparison of scope of services.	4.12.02	Baker	22
Bureau of Eligibility Services				
24	•61. Define primary care. [op]	2.22.02	Ipsen	1
86	62. Define process for identifying PEHP-based recipients so education about benefits can occur	3.15.02	Stokes	1
26	•63. Write eligibility policy for PCN program [op]	3.01.02	Stokes	1
28	*121. Write/transmit to IT 495 on eligibility*	*3.12.02*	*Stokes*	*27*
49	64. Draft new rules on eligibility for the PCN	3.08.02	Stokes cChristense n	1
88	65. Design, print and distribute application form	5.31.02	Stokes	27
89	66. Prepare transition plan for UMAP clients into PCN	3.22.02	Ipsen Knudson	1
91	*122. Begin UMAP transition*	*4.01.02*	*Ipsen Knudson*	*89*
105	*123. Coordinate with DWS on collecting enrollment fees*	*3.26.02*	*Knudson*	*104*
92	67. Distribute client specific notices to 1931 and medically needy recipients explaining the change in benefits and co-payments.	5.31.02	Stokes	117
93	68. Develop an article for the client	5.15.02	Pickle	14,16,18

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
	newsletter explaining all applicable changes to the program.			
94	69. Review current eligibility manuals for changes	3.12.02	Stokes cChristense n	27
95	70. Rewrite eligibility manuals	3.26.02	Stokes cChristense n	94
96	71. Review of new eligibility manuals (circulate for review and comment)	4.02.02	BES staff	95
97	72. Finalize new eligibility manuals	4.09.02	Stokes cChristense n	96
98	73. Assess required PACMIS changes.	2.22.02	Stokes	1
99	74. Coordinate with DWS on required PAC-MIS changes.	2.22.02	Stokes	98
101	75. Develop staff training plan, preparations, schedules and training packages on new eligibility manuals and PACMIS changes	5.31.02	Schouten Evans Olsen	97
102	76. Provide staff training in new eligibility manuals, new state rule and state plan changes, and PACMIS changes	6.21.02	Stokes	101
103	77. Implement the new eligibility manuals and changes	6.28.02	BES staff	102
29	•78. Complete a detailed discussion of the income limits to be used for the program [op]	3.15.02	Stokes	1

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
104	79. Detail enrollment fee collection ~~and coordinate with DWS~~. REVISED	3.26.02	Knudson	18
105	*123. Coordinate with DWS on collection of enrollment fees*	*3.26.02*	*Knudson*	*104*
30	•80. Detailed description of all groups eligible for the demonstration; the process for eligibility determination and annual redetermination, enrollment/ disenrollment and procedures for ensuring that applicants will be placed in the plan most beneficial to them [op]	3.15.02	Stokes	1
31	•81.Describe outreach plans; types of media to be used; geographical areas to be targeted; dissemination locations for outreach materials; bilingual and interpretive methods; and how state will review and approve marketing materials prior to use. [op]	3.15.02	Stokes	1
32	•82. Describe any procedures for establishing and maintaining waiting lists. [op]	3.15.02	Stokes	1
Bureau of Medicaid Operations				
106	83. Review and develop provider training packages, plan, schedule, and packages for changes in state plan, new state rules	5.14.02	Kramer	74,69
107	84. Print provider training packages ~~and install on the web.~~ REVISED	5.21.02	Kramer	106
108	85. Mail provider training packages	5.22.02	Kramer	107
110	88. Provide training in new provider	6.26.02	Kraeling	108,109

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
	manuals			
111	89. Coordinate with First Data Bank	3.19.02	Mcquire	16
109	*124. WEB install provider training packages*	*5.29.02*	*Kramer*	*106*
Bureau of Managed Care				
112	90. Amend the division's 1915(b) Freedom of Choice waivers	3.28.02	Ford Christensen	1
113	*131. Submit 1915b amendments to CMS*	*4.01.02*	*Olson*	*112*
114	*132. CMS approves 1915b amendments*	*6.28.02*	*CMS*	*113*
115	91. Draft client specific materials to 1931 and medically needy recipients explaining the change in benefits and co-payments.	3.29.02	Graver Fuhriman	86
116	92. Review and finalize client specific materials to 1931 and medically needy recipients explaining the change in benefits and co-payments.	4.30.02	Graver Fuhriman	115
117	93. Print client specific materials to 1931 and medically needy recipients explaining the change in benefits and co-payments.	5.31.02	Graver Fuhriman	116
118	94. Develop training for staff and contractors (local health departments)	4.19.02	Graver Fuhriman	12,14,16,18,66,68
119	95. Print training materials for staff and contractors (local health departments)	5.31.02	Graver Fuhriman	118
120	96. Deliver training for staff and contractors (local health departments)	6.28.02	Graver Fuhriman	119
66	97. Rewrite CHEC provider manual	3.28.02	Olson	64
64	98. Describe scope of service for CHEC	3.12.02	Olson	1

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
	and transmit for rate setting			
67	99. Describe scope of service for mental health and transmit for rate setting	3.12.02	Ford	1
128	*Transmit CHEC & MH scopes for rate setting*	*4.01.02*	*Olson Ford*	*64,67*
68	100. Rewrite TCM, PMHP provider manuals	3.28.02	Ford	67
121	101. Complete HMO contract amendments	4.30.02	Ford Christensen	12,14,16,18,66,68
33	•102. Write Quality assurance plan [op/ia]	3.15.02	Guterriez Hudson Christensen	1
34	•103. Describe the delivery systems for current eligibles, and Populations I and II as defined in the Terms and Conditions [op]	3.15.02	Olson	1
35	•105. Describe operational details for enrollment caps and process for revising the limits; [op]	3.15.02	Roner Wood	1
36	•106. Prepare to meet financial requirements as outlined under Attachment A of the Terms and Conditions. [op]	3.15.02	Roner	1
Information Technology Unit				
44	108. Program Scope of Services requirements	6.28.02	Higley	41
46	109. Program cost sharing	6.28.02	Higley	43
84	110. Program eligibility	6.28.02	Higley	28
83	111. Program rate structure	6.28.02	Higley	82

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PERT Chart ID Number	Task	Due Date	Assigned	PERT ID Precedents
122	112. Program provider files	6.28.02	Higley	21,73
45	113. Program pharmacy changes	6.28.02	Higley	42
123	114. Implement Required MMIS Changes	6.28.02	Higley	44,45,46,83,84
Other				
51	115. Chief of Staff approval of rules	3.22.02	Springmeyer	50
52	116. Executive Director's approval of rules	3.29.02	Betit	51
	119. Develop a public notice of the expansion of eligibility and program description to be distributed throughout the community. NOT INCLUDED ON PERT		Kittering McDonald from DOH	
100	120. Complete PACMIS programming	6.28.02	DWS	99
124	*121. Implement PACMIS programming*	*6.28.02*	*DWS*	*100*
125	*129. PCN enrollment begins*	*7.1.02*	*Medicaid*	Everything

3.10 Benefits

With the implementation of the waiver project, the DHCF will provide three benefit plans depending on specific eligibility criteria: Traditional Medicaid, Non-Traditional Medicaid, and the PCN. The following chart shows a brief comparison of benefits of the three plans.

Chart 2: Comparison of Traditional Medicaid, Non-Traditional

Medicaid, and PCN Plan Benefits

Benefit	Traditional Medicaid	Non-Traditional Medicaid	Primary Care Network
Hospital Services	Inpatient, Outpatient, Emergency Department	Inpatient, Outpatient, Emergency Department services. Additional surgery exclusions than traditional Medicaid	Emergency Services in Emergency Room only
Physician Services	Services by licensed physicians and other health professionals	No reduction, same as traditional Medicaid	Services by licensed physicians and other health professionals for primary care services only
General Preventive Services	Screening Programs (changes the scope of traditional coverage)	Assumed under physician services	Assumed under physician services
Vision Care	Eye Exams, Lenses, Eyeglass frames, contact lenses	One eye examination every 12 months, no eyeglasses	One eye examination every 12 months, no eyeglasses
Lab and Radiology Services	Included	No reduction, same as traditional Medicaid	Lab and Radiology only as part of primary care services
Physical Therapy	Physical Therapy services by licensed PT professional	Visits to a licensed PT professional (limited to a combination of 16 visits per policy year for PT, OT and Chiropractic services)	None
Occupational Therapy	Occupational Therapy services by licensed OT professional	Visits to a licensed OT professional (limited to a combination of 16 visits per policy year for PT, OT and Chiropractic services)	None
Chiropractic Services	Covered through CHP	Included with PT/OT	Not covered
Speech and Hearing Services	Covered only for children and pregnant women	Covered for pregnant women only	Not covered
Podiatry Services	Covered only for children and pregnant women	Covered for pregnant women only	Not covered
End Stage Renal Disease - Dialysis	Treatment of end stage renal dialysis for kidney failure	No reduction, same as traditional Medicaid	Not covered
Home Health Services	Home health services	No reduction, same as traditional Medicaid	Not covered
Hospice Services	Services to terminally ill	No reduction, same as	Not covered

Benefit	Traditional Medicaid	Non-Traditional Medicaid	Primary Care Network
	patients (6 months life expectancy)	traditional Medicaid	
Private Duty Nursing	Services by licensed nurses for ventilator-dependent children	Not covered	Not covered
Medical Supplies and Medical Equipment	Necessary supplies and equipment used to assist in enrollees medical recovery (durable and non-durable equipment limited by code)	Same as traditional Medicaid with exclusions.	Equipment only for recovery (see detail list)
Abortions and Sterilizations	Provided to the extent permitted by Federal and state law	Same as traditional Medicaid with exclusions.	Not covered
Treatment for Substance Abuse and Dependency	Medical detoxification for alcohol and substance abuse conditions	Same as traditional Medicaid	Not covered
Organ Transplants	Kidney, liver, cornea, bone marrow, heart, intestine, lung, pancreas, small bowel, plus combinations of above	Kidney, liver, cornea, bone marrow, stem cell, heart and lung (includes organ donor)	Not covered
Long Term Care	Care at skilled nursing facilities	Not covered	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies. Non-emergency transportation is provided with some limitations.	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Services to CHEC Enrollees	Preventive Screening and other services following written policies	Not applicable	Not applicable
Family Planning Services	Information, counseling and treatment relating to family planning services including: Birth Control Pills, Norplant, Depo Provera, IUDs, Diaphragms, Cervical Caps, Vasectomy or Tubal Ligations and re-	Same as traditional Medicaid Services except for the following which are NOT covered: Norplant, infertility drugs, in-vitro fertilization, genetic counseling	Consistent with physician and pharmacy scope of services. NOT covered: Norplant, infertility drugs, in-vitro fertilization, genetic counseling, vasectomy, tubal ligation

Benefit	Traditional Medicaid	Non-Traditional Medicaid	Primary Care Network
	lated exams		
High-Risk Prenatal Services	Appropriate coordinated care including risk assessment, prenatal screening (a defined program)	Appropriate coordinated care including risk assessment, prenatal screening (a defined program)	Not covered
Medical and Surgical Services of a Dentist	Care for pain relief of dental related problems. This service does NOT include fillings, pulling of teeth, treatment of infections or other in dental office procedures	No reduction, same as traditional Medicaid	Not covered
Health Education including Diabetes and Asthma	Limited Medicaid services	Same as traditional medicaid	Not covered
Pharmacy	Generic substitution. $1 co-pay up to $5 per month.	Utilization review process for more than 7 prescriptions per month; Generic substitution; $2 co-pay, and some limitations on drugs available	Pharmacy services limited to 4 prescriptions per month, $5 co-pay for drug on preferred list, 25% co-pay for drugs not on list.
Dental	Covered for children and pregnant women only. Remaining population limited to services to address relief of pain and infection	Covered for pregnant women only. Remaining population limited to services to address relief of pain and infection	Limited scope of service: Exams, Preventive services, Fillings, and Limited extractions.
Mental Health	Outpatient FFS and prepaid mental health services.	30 day inpatient per year; 30 outpatient visits per year; also other exclusions. Can substitute IP days for OP days.	Not covered
Outpatient Substance Abuse	Services for substance abuse under FFS.	Services for substance abuse under FFS, according to certain exclusions	Not covered
Home and community Based Waiver Services	Yes	Services of the Home and Community Based Waiver are to a population different than the population of the Primary Care Wavier and therefore does not apply (i.e. this waiver is	Services of the Home and Community Based Waiver are to a population different than the population of the Primary Care Wavier and therefore does not apply (i.e. this waiver is

Benefit	Traditional Medicaid	Non-Traditional Medicaid	Primary Care Network
		for elderly and disabled)	for elderly and disabled)
Targeted Case Management for the Chronically Mentally Ill	Part of PMHP (Prepaid Mental Health Plan) and billed FFS by FFS mental health center	Targeted Case Management for the Chronically Mentally Ill sessions/visits count toward the 30 outpatient session/visit limit per enrollee per year (see Mental Health above)	Not covered
Targeted Case Management for Substance Abuse	Yes	Not a covered benefit	Not covered
Targeted Case Management for Homeless	Yes	Same as traditional Medicaid	Not covered
Targeted Case Management for HIV/AIDs	Yes	Same as traditional Medicaid	Not covered
Other Outside Medical Services	Yes	Discretionary services provided in freestanding centers	Not covered
Interpretive Services	Yes	Same as Traditional Medicaid	Same as Traditional Medicaid
Note: For Non-Traditional Plan: Other services, if deemed medically necessary upon review, will be provided.			

3.10.1 The scope of service provided to "Traditional Medicaid" eligibles is that contained in the state plan. This scope will continue to be provided to the standard categories of eligibility. The complete scope of service for this population will not be detailed here, but may be reviewed by referencing the Medicaid state plan.

3.10.2 The scope of service for the "Non-Traditional Medicaid" population, previously referred to in the waiver application as the PEHP-based population, and identified in the T&C as the "Current Eligibles," is listed hereunder.

General Policy. The Non-Traditional Medicaid plan to be provided

to the 1931 TANF adults, medically needy, and transitional Medicaids, represents a reduced benefit plan for these groups that previously received full benefits and services under the Medicaid state plan. Services under this plan are similar to the current traditional Medicaid plan with some limitations and exclusions. Those eligible for the services under this plan are adults age 19 or older:

a) with children currently being served under Medicaid;

b) or who are transitioning into the workforce and eligible to receive medical assistance while making the transition to economic independence;

c) or who are medically needy, not disabled or spend down to establish eligibility.

3.10.2.1*Hospital Services*

Hospital services encompass medical, surgical, or level of care needs which require the availability of specialized diagnostic and therapeutic services and close medical supervision of care and treatment directed toward improvement, maintenance, or protection of health or lessening of illness, disability or pain.

Services based on physician orders. Coverage of these services includes use of hospital facilities, equipment and supplies; the technical portion of clinical laboratory and radiology services; nursing; medical social services and therapy services.

Inpatient hospital services can be provided by bed occupancy for 24 hours or more in an approved acute care general hospital under the care of a physician when the admission meets the established criteria for severity of illness and intensity of service.

Diagnostic services performed by the admitting hospital or by an entity wholly owned or operated by the hospital within three days prior to the date of admission to the hospital are deemed to be inpatient services and are covered under the DRG.

Outpatient hospital services must be medically necessary, diagnostic, therapeutic, preventive or palliative and provided for less than 24 hours in outpatient departments located in or physically connected to an acute care general hospital.

Emergency department services must be provided in designated acute care general hospital emergency departments. Emergencies result from serious, traumatic injury or illness which if not treated in a reasonable period of time after occurrence could lead to disability or death.

Medical supplies, appliances, and equipment which are medically necessary and required for the care and treatment of a patient during the inpatient stay are covered Medicaid services under the DRG providing they meet established standards and limits identified in policy.

Drugs and biologicals appropriate for inpatient care and approved by the federal Food and Drug Administration are covered based on medical need and physician order. The drugs must be given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug.

Medicaid documents which support policy for hospital services will be incorporated, by reference, to implement this plan. The documents are:

a) The *Medicaid UB-92 Revenue Code List*. revenue codes and ICD.9.CM diagnosis codes are the main means of documentation for hospital services.

b) The *Hospital Surgical Procedures List* is specific to hospitals.

The procedures on this list are those with federal requirements which must be upheld, along with other procedures requiring careful monitoring for payment to be made. The listed procedures have the associated ICD.9.CM diagnosis codes, the associated CPT code for physician use, and the criteria specific to review of the procedures requiring prior authorization. Adherence to the requirements of this list is essential to payment for hospitals.

c) The *Medicaid Medical and Surgical Procedures List* is a comprehensive list of codes and services. This list is taken from the *Physician's Current Procedural Terminology Manual,* and it can serve as a guide to covered services as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic or not reasonable or medically necessary. Non-specific or unlisted codes are included and require physician review because of the potential for use to cover otherwise non-covered services.

The list also identifies federally controlled hysterectomy, sterilization and abortion procedures that have strict requirements related to payment for both physician and hospital. The list also identifies transplant procedures, and those procedures which require prior authorization based on specific coverage criteria.

d) Emergency Department Services approved for coverage are found on the *Diagnoses for Emergency Department Reimbursement List.* Any code other than those listed would be a non-covered service resulting in decreased payment. The diagnoses in the

Authorized Emergency Department List are ICD.9.CM codes.

3.10.2.2 *Limitations For Hospital Services*

a) Hospital services are coded by ICD.9.CM codes and by UB-92 Revenue Codes. Current coverage/non-coverage is documented on the *Revenue Code List.*

b) The *Hospital Surgical Procedures List* outlines transplant procedures, sterilization, hysterectomy, and abortion procedures which have associated federal limitations; in addition to other procedures which require monitoring for utilization. Associated with each procedure is the applicable ICD.9.CM diagnosis code, the related CPT Code (for physician use), and the designated, established criteria to be used by the agency in prior authorization review and approval. All elements of the criteria must be met for payment to be made for any of these procedures.

c) There are additional limitations on procedures which are cosmetic, experimental or otherwise non-covered, or require prior authorization. These limitations are listed the *Medicaid Medical and Surgical Procedures List.* This list also identifies appropriate ICD.9.CM diagnosis codes and criteria to be used for prior authorization review where applicable. These limitations are consistent with surgical exclusions outlined under Section 4.5.02 of the waiver.

d) Organ Transplant Procedures are limited to those for kidney, liver, cornea, bone marrow, stem cell, heart and lung.

e) Rehabilitation services are limited to those which meet criteria established by policy and reviewed through the Utilization Management Unit prior authorization process prior to the

service.

f) Emergency department services are limited to those identified by ICD.9.CM discharge diagnosis codes on the *Medicaid* Authorized Diagnoses for Emergency Department Reimbursement List. Any code other than one of those listed would be considered non-emergency use of the emergency room and subject to adjusted reimbursement.

g) Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification only. Any continuing therapy must be accessed under the outpatient mental health or psychiatric services benefit as appropriate.

h) Abortion procedures are limited to:

i. those where the pregnancy is the result of an act of rape or incest, or

ii. a case, with medical certification of necessity, where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by, or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (42 CFR 441.203)

i) Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441 Subpart F which is adopted and incorporated by reference.

j) Cosmetic, reconstructive, or plastic surgery is limited to:

i. correction of a congenital anomaly;
ii. restoration of body form following an accidental injury; or
iii. revision of severe disfiguring and extensive scars resulting from neoplastic surgery.

k) Laboratory services are limited to those tests identified by the Centers for Medicare and Medicaid Services for which the individual laboratory is CLIA certified to provide, bill and receive payment.

l) Observation or treatment room services are limited to 24 hours or less for cases where there is need for observation and evaluation to establish a diagnosis or the appropriateness of an inpatient admission. Use of observation status to submit ancillary charges associated with outpatient surgery, other outpatient diagnostic services, or other outpatient stays for any reason is excluded from reimbursement.

3.10.2.3*Physician Services*

Physician services provide for the medical needs of eligible individuals and must be provided within the parameters of accepted medical practice. Physician services may be provided directly by the physician, osteopath, or by other professionals – nurse practitioners, nurse mid-wives, or physician assistants, authorized to serve the health care needs of the practice population through an approved scope of service under the physician's supervision.

Physician services include surgery and anesthesia.

Certified family or pediatric nurse practitioners are limited, under this Medicaid scope of service, to a cooperative ambulatory,

office type, working relationship with a physician. When employed by the physician, the physician bills for the service

Physician assistants work under the supervision of a physician to provide service to patients within the practice population.

Certified registered nurse midwives (CNMs) practice with relative independence under their scope of licensure and in association with obstetrician/gynecologists or other physicians from whom they can seek consultation, or refer high risk patients when necessary. CNMs practice under a Medicaid scope of service, including unique codes, approved for their specialty.

The *CPT Manual* is the standard for defining and coding physician services. Not all procedures are acceptable, e.g., experimental, cosmetic, or those not reasonable and medically necessary or cost effective. Nonspecific or unlisted services require physician review because of the potential for use to cover otherwise non-covered services. The CPT office visit, Evaluation and Management codes (99201 - 99215) for either new or established patients must be used appropriately.

The *Medicaid Medical and Surgical Procedures List* will be used to help govern this program. This list serves as a guide as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic, or not reasonable and necessary. The list applies to office service or to surgical procedures.

3.10.2.4*Limitations for Physician Services*

a) The ***CPT Manual*** is the standard for defining and coding physician services. However, not all procedures are covered under the plan, e.g., experimental, ineffective, cosmetic, or those non-

cost effective, reasonable or necessary.

b) Use of non-specific or unlisted codes to cover procedures not otherwise listed in the ***CPT Manual*** require physician review and approval because of the potential for use to cover otherwise non-covered services.

c) Limitations on physician services and medical visit exclusions listed under Section 4.5.04 of the Waiver are identified in the *Medicaid Medical and Surgical Procedures List*. Implementation of this list will provide appropriate edits.

d) Evaluation/management office visit codes (CPT) for new and established patients (99201 - 99215) must be used appropriately on claims for service.

e) Office visit codes (E/M 99201 through 99215) and service codes 10060 through 69990 and 90780 through 99199 will not be paid on the same date of service.

f) After-hours office visit codes cannot be used in a hospital setting, including emergency department by private or staff physicians. They cannot be used for standby for surgery, delivery, or other similar circumstances, and they cannot be used when seeing a new patient.

g) Subsequent hospital care codes 99231 through 99233 should not be billed following any surgical procedure. Surgical procedures are covered by a global fee.

h) Cognitive services are limited to one service per day by the same provider.

i) Office or hospital visits one day prior or the same day as a surgical procedure are considered part of the global surgical

procedure and paid accordingly.

j) Substance abuse and dependency treatment is limited to specific provider groups with some service limitations.

k) Modifier 25 will not be recognized as a stand alone entity to override the one service per day limitation.

l) Modifier 57 will not be recognized. A decision for surgery is an integral part of office visits covered before or immediately prior to the preoperative office visit that is part of the global fee.

m) Laboratory services provided by a physician in his office are limited to the approved kits, waived tests or those laboratory tests identified by CMS for which each individual physician is CLIA (Clinical Laboratory Improvement Amendments) certified to provide.

n) A specimen collection fee is limited only to specimens drawn under the supervision of a physician to be sent outside of the office for processing.

o) Finger, heel, or ear sticks for blood analysis are limited only to infants.

p) Anesthesia services are limited to those provided directly to a patient in conjunction with authorized, covered surgical services. Monitored or standby service is not covered.

q) Contact lenses are covered only for severe eye disease or difficult visual correction, e.g, aphakia, nystagmus, keratoconus, severe corneal distortion, cataract surgery and in cases where visual acuity cannot be corrected to at least 20/70 in the better eye.

r) Abortion procedures are limited consistent with 42 CFR 441.203. See

Criteria # 17 attached to the *Medicaid Medical and Surgical Procedures List*.

s) Hysterectomy and sterilization procedures are limited to those which meet the requirements of 42 CFR Subpart F. See Criteria #10 attached to the *Medicaid Medical and Surgical Procedures List*.

t) Removal of benign or pre-malignant skin lesions are limited by criteria #34 attached to the *Medicaid Medical and Surgical Procedures List*.

u) Trigger point injections are limited by criteria #33 attached to the *Medicaid Medical and Surgical Procedures List*.

v) Magnetic resonance imaging procedures are limited to coverage only for the brain, spinal cord, hip, thigh and abdomen.

w) Vitamins are limited to coverage for pregnant women, children through age 5, and Vitamin B-12 only for patients with pernicious anemia.

x) Drugs and biologicals are limited to those approved by the Food and Drug Administration or the local Drug Utilization Review Board which has the authority to approve off label use of drugs.

y) Seeking additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration for additional reimbursement.

3.10.2.5*Vision Care*

Covered vision services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice are limited to:

eye refractions/examinations – No glasses
one exam every 12 months

The following codes are covered 92002, 92012, 92015

3.10.2.6*Lab and Radiology Services*

Professional and technical laboratory and radiology services are furnished by certified providers with use of the 70000 and 80000 series of codes.

Laboratory services are limited under federal CLIA regulations.

a) All laboratory testing sites providing services must have either a CLIA certificate of waiver or a certificate of registration along with a CLIA identification number.

b) Only laboratories CLIA certified can complete certain tests and receive payment.

c) Federal regulation has identified the CLIA limited procedures as well as those tests (approximately 8 tests) and test kits (approximately 50) that can be used by physicians in the office to provide service.

d) Some laboratory and radiology procedures are non-covered and listed on the *Medicaid Medical and Surgical Procedures List* because they relate to otherwise non-covered services. (Consistent with

exclusions under Section 4.5.05 of the Waiver).

3.10.2.7*Physical Therapy/Occupational Therapy/Chiropractic Services*

Treatment and services provided by a licensed physical therapist, occupational therapist, or chiropractor.. (Occupational therapy may be included for fine motor function.)

a) Coverage includes a maximum of 16 visits per policy year in any combination.

b) Treatment and services for physical therapy and occupational therapy must be authorized by a physician.

c) Authorized codes are:

Physical Therapy:Y0010; Y9999; and Y0011
Occupational Therapy:Y5302 and Y5303
Rehabilitation Centers:Y5304; Y5305 and Y5306
Chiropractic:Sole source contract through Chiropractic Health Plan

3.10.2.8*Hearing Services*

Audiology services were eliminated by the 2002 legislature. Waiver amendment will follow.

3.10.2.9*Podiatry Services*

Podiatry services were eliminated by the 2002 legislature. Waiver amendment will follow.

3.10.2.10*End Stage Renal Disease - Dialysis*

Treatment of end stage renal failure by dialysis. Dialysis is to be rendered by a Medicare-certified dialysis facility which has met the standards for operation and maintenance of end stage renal disease facilities in order to provide safe and effective services.

Covered codes for the facility are:

Revenue codes 821, 831, 841, or 851
634 Epoetin Alpha (EPO) < 10,000 units
635 EPO > 10,000 units or more

Covered physician CPT codes are:

90935; 90937; 90945; and 90947

3.10.2.11*Home Health Services*

Home health services are defined as intermittent nursing care provided by certified nursing professionals—registered nurses and licensed practical nurses[3]—in the client's home when the client is homebound or semi-homebound.[4] Home health care is to be rendered by a Medicare-certified home health agency.

Covered home health codes are:

Y0100; Y0117; Y0151; Y0101; Y0111; Y0106; Y0102; Y0103; Y0104; Y0105; Y0112; Y0113; Y0114; Y0115; Y0107 and Y0108. (These codes may be consolidated and changed with HIPPA Implementation.)

[3]a skilled nurse aide also provides service as appropriate.

[4]reference to homebound or semi-homebound has been removed from the state plan at the request of CMS and replaced with "place of residence when the home is the most appropriate and cost effective setting consistent with the client's medical need."

3.10.2.12*Speech Therapy*

Speech therapy services was eliminated by the 2002 legislature. Waiver amendment will follow.

3.10.2.13*Hospice Services*

Hospice services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are to be rendered by a Medicare-certified hospice.

Covered codes by geographic area are:

Salt Lake/Davis/Weber County: Y8000; Y8001; Y8002; Y8003; Y8004 and Y8015

Utah County: Y8005; Y8006; Y8007; Y8008; Y0889 and Y8015

All Other Counties: Y8010; Y8011; Y8012; Y8013; Y8014 and Y8015

3.10.2.14*Abortions and Sterilizations*

Abortions and sterilization services are provided to the extent permitted by federal and state law and must meet the documentation requirements of 42 CFR 440 Subparts E and F. Abortion services to unmarried minors must have written notification of the parent or legal guardian.

These procedures are identified on the *Medicaid Medical and Surgical Procedures List*, as requiring prior authorization and listing the specific criteria that must be met to approve a service consistent with 42 CFR 440 Subparts E and F. Related ICD.9.CM

diagnosis codes are also listed.

Covered codes for sterilization (male and female) are:

55250; 55450; 55530; 55535; 55540; 55550; 55600; 55605; 55650; 58563; 58600; 58605; 58611; 58615; 58661; 58670 and 58671.

Covered codes for abortion which meet federal and state law:

59100; 59840; 59841; 59850; 59851; 59870 and 59852;

3.10.2.15*Organ Transplants*

Covered transplantations for all enrollees are: kidney, liver, cornea, bone marrow, stem cell, heart and lung; unless amended under the contract provisions for this health plan.

Codes covering these procedures are listed on the *Medicaid Medical and Surgical Procedures List* identified as requiring prior authorization and listing specific criteria that must be met to approve a service.

Covered Codes are:

Bone Marrow: 38240 and 38241
Cornea: 65710
Heart: 33945
Kidney: 50360; 50365 and 50380
Liver: 47135 and 47136
Lung: 32851; 32852; 32853 and 32854
Stem Cell: 38240 and 38241

3.10.2.16*Other Outside Medical Services*

The health plan, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, surgical centers and birthing centers.

Emergency Centers: These facilities, (InstaCare type) function as a physician office where ambulatory physician services are provided, usually on a schedule outside of usual physician office hours. Covered codes would be CPT codes appropriate for the office service. ICD.9.CM diagnosis codes may also be present to identify the reason for the service. There is no facility charge paid to such centers.

Surgical Centers: These facilities, free standing, may provide outpatient surgery services appropriate for such a setting. Established criteria are applicable to services provided in this setting, i.e., prior authorization, exclusions, experimental or non-covered procedures, etc. Facility payment would be based on the CPT procedure code listed.

Birthing Center: Free standing birthing facilities are limited. These facilities are usually staffed with certified registered nurse midwives who work with physicians to provide the service. (Specific "Y" codes are available if the CNM's provide the direct service. The one functioning facility has an arrangement that does not include direct billing.) Code Y0615 is available for this facility to use for a facility charge.

3.10.2.17*Transportation Services*

Transportation services include only:

Ambulance (ground and air) service for medical emergencies. (Non-emergency transportation of any kind is

not covered.)

Covered codes listed as:

A0425; A0429; A0430 and A031.

3.10.2.18*Preventive Services and Health Education*

Preventive Services and Health Education includes preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management.

These services are assumed under the general evaluation and management care provided to patients by the physician during medical visits. The services include counseling, anticipatory guidance, and/or risk factor reduction interventions. No special programs are covered.

Immunization codes are available:

Administration fee: 90471 - 90474
Specific immunization agent: 90476 - 90749

3.10.2.19*Family Planning Services*

Family planning services include disseminating information, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. All services must be provided or authorized by a physician, certified nurse midwife, or nurse practitioner, must be provided in concert with Utah law, and must include prior written consent of a minor's parent or legal guardian. (See Section 4, Non-Covered Services for specific non-covered services.)

3.10.2.20*Pharmacy Services*

The Medicaid pharmacy policy as set forth in the *Pharmacy Manual for Utah Medicaid* clients is hereby adopted for the Non-Traditional Medicaid group of clients with the following changes. Coverage is more restrictive for units; for example, see 3.10.2.20.2 j) below. The pharmacy program will comply with all regulations implementing section 1927 of the Social Security Act.

Pharmacy services include most, but not all, prescribed drugs and compounds provided by a licensed pharmacy. Injections are limited with prior approval. The fact that a provider may prescribe, order, or approve a prescription drug service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. A select list of OTC drugs is covered.

3.10.2.20.1*Drug Limitations:*

a) This program has a utilization review process when more than seven prescriptions per client per month are purchased.

b) The co-pay per client per prescription is $2.00 for name brand or generic product.

c) There is no maximum co-pay specific to prescription drugs. Co-payments will be applied toward the $500 out-of-pocket maximum.

d) Prior approval and the criteria governing such are the same as the regular Medicaid program. A list of current drugs requiring prior approval is attached.

e) Generic products with an A B rating are mandated for dispensing.

f) Name brand drugs where generics are available will require full payment by client.

3.10.2.20.2*Pharmacy Exclusions*:

a) Injectable products are available for payment only by prior approval. This includes but is not limited to

Anzemet Kineret
Enbrel Kytril
Fragmin Lovenox
Heparin Zofran
Insulin pens, cartridges, pre-filled syringes

Insulin in 10 ml vials will be covered.

b) No overrides from generic to name brand will be covered even with a physician's override request; no "dispense as written" (DAW).

c) No duplicate prescription will be paid for lost, stolen, destroyed, spilled or otherwise non-usable medication with some exceptions. The exceptions cover antibiotics, anti-convulsants, and other life-saving drugs by prior approval.

d) Over-the-counter products are on the attached approval list.

e) No compounded prescriptions covered.

f) No lozenges, suckers, rapid dissolve, lollipop, pellets, patches or other unique formulation delivery methodologies developed to garner "uniqueness" will be covered, unless they are the only routes of administration. Oral formulations are limited to tablets, capsules or select liquids.

g) Drugs are covered for labeled indications only.

h) Therapeutic duplication may be selectively disallowed or allowed by the DUR Board.

i) Specific classes of drugs are excluded by OBRA 91 law statue.

   i. Weight gain or loss
   ii. Cosmetic preparations
   iii. Patches
   iv. Vitamins except prenatal
   v. Minerals

j) Cumulative amounts of certain products for 30 days include the following:

   i. Carisoprodol (Soma) - 60
   ii. Cox-2 inhibitors (Celebrex, Vioxx, Bextra) - 33
   iii. Oral APAP/narcotic combinations - 180
   iv. Oxycodone LA (Oxycontin) - 120
   v. PPIs - 31 with prior approval for override.
   vi. Preven - 2
   vii. Stadol NS - 5

viii. Tryptans (for migraine headache) - 9
ix. Ultram/Ultracet - 90
x. Viagra - 5

k) There are no "grace" periods to obtain the above drugs early.

3.10.2.21*Mental Health*

Inpatient Services. There is a 30-day maximum per year for inpatient care. Residential treatment may be provided in lieu of inpatient care. The 30 day maximum per year also applies to residential care, or any combination of inpatient and residential.

a) If an enrollee would be otherwise hospitalized for treatment of a mental illness or substance abuse, and in lieu of hospitalization, a lower level of care can be used; then

b) the lower level of care may be substituted at a rate of one outpatient visit in lieu of each inpatient day which would be otherwise required.

Outpatient services/visits. There is a maximum of 30 visits per enrollee per year for outpatient services. Substitution of inpatient days may be made if the client requires more than 30 visits per year. Example: If a client required 35 outpatient visits during an annual period, a substitution of 5 inpatient days could be made, thereby leaving a maximum of 25 inpatient days.

3.10.2.22*Dental Services*

Adult dental services were eliminated by the 2002 legislature. Limited to services to address relief of pain and infection. Waiver amendment to follow.

3.10.2.23*Medical and Surgical Services of a Dentist*

Care for relief of pain and dental problems. This service does not include fillings, pulling of teeth, treatment of infections or other in dental office.

3.10.2.24*Interpretive Services*

Interpretive/medical translation services will be provided by entities under contract to Medicaid for people with limited English proficiency and for the deaf.

No specific codes are identified. When providers use the Medicaid authorized interpretive services, payment is made to the entity under terms of the signed contract. Medical providers may use their own interpreters. However, independent interpreters cannot bill nor be paid by Medicaid. Payment remains the responsibility of the provider who secured their services.

3.10.2.25*Non-Covered Service*

a) Services listed as exclusions for hospital service under section 4.5.01 of the waiver are currently non-covered on the recommended *UB-92 Revenue Code List* and the *Medicaid Medical and Surgical Procedures List*. Some additional exclusions need to be made on the *UB-92 Revenue Code List*. The codes are:

    i. Occupational therapy: 430 through 439
    ii. Whole blood: 380 through 382, and 391
    iii. Autologus (self) blood storage for future use: 390 and 399
    iv. Organ donor charges: 811 through 813 (810 and 814 through 819 are already closed.)

b) Surgical exclusions listed under section 4.5.02 of the waiver are all currently non-covered on the *Medicaid Medical and Surgical Procedures List,* both the hospital version and the

CPT physician list

c) Anesthesia exclusions noted under section 4.5.03 of the waiver are supported by links to the procedures that are identified as non-covered or ineligible.

d) Medical visit exclusions noted under section 4.5.04 of the waiver are covered under limitations or as listed on the *Medicaid Medical and Surgical Procedures List.*

e) Additional hospital or physician exclusions are:

f) Office visits in conjunction with allergy injection.

Excluded codes are:

95115 through 95134, and 95144 through 95199.

g) Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.

h) Nutritional counseling or analysis.

Excluded codes are:

97802 through 97804.

i) Vision therapy.

j) Contact lens' are not covered for moderate visual improvement or for cosmetic purposes.

k) Tobacco abuse counseling and therapy.

l) Take-home medication from a provider's office.

m) Rolfing or massage therapy.

Excluded code is:

97124

n) Care, treatment or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.

o) Prolotherapy or chelation therapy.

p) Office calls in conjunction with repetitive therapeutic injections.

q) Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school.

Excluded codes are:

97005, 97006, 97537, 97545, 99080.

r) Special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's office.

s) Treatment of routine foot care such as weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics and arch supports; palliative care of metatarsalgia or bunions, corns, warts, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease, such as diabetes.

Excluded Codes are:

11055 through 11057; 11719 through 11721; 97504; 97520

and 97703.

t) Services or complications incurred as an organ or tissue donor.

u) Long term care:

v) Private duty nursing.

w) Services excluded as family planning services:

Norplant: 11975, 11976, 11977.

Infertility studies and reversal of sterilization: ICD.9.CM diagnosis codes:

Male—606.0 through 606.96 and CPT Procedure Codes: 54240; 54250; 54900; 54901; 55200; 55300 and 55400.

Female—256.0 through 256.9; 628.0 through 628.9 and CPT Procedure Codes: 58345; 58350; 58750; 58752; 58760 and 58770

Assisted Reproductive Technologies (ART's) (in-vitro): ICD.9.CM diagnosis code: V26.1 and above infertility diagnosis codes; ICD.9.CM procedure codes: 66.1; 66.8; 69.92; 87.82, 87.83; CPT procedure codes: 58321 through 58323; 58970; 58974; 58976; 89250 through 89261; 89264 and 89321.

Genetic Counseling: ICD.9.CM diagnosis code: V26.3, V65.40, V25.09; CPT Procedure codes for cytogenetic studies: 88230 through 88299. (Genetic counseling is being covered to some extent by Medicaid through

laboratory tests, counseling under office calls, and other sources that cannot be identified.)

3.10.2.26*General Exclusions*

a) Services which fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature.

b) Services primarily for convenience, contentment, personal, or other non-therapeutic purposes.

c) Services which are not reasonable and necessary for the patient's medical care.

d) Charges for services which the insured is not, in the absence of coverage, legally obligated to pay.

e) Shipping, handling or finance charges.

Excluded Codes:

99000 through 99002.

f) Services or medical care rendered by an immediate family member.

g) Services received as a result of an industrial accident or illness, any portion of which, is payable under workman's compensation or employer's liability laws.

h) Services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.

i) Expenses in connection with appointments scheduled and not kept.

j) Completion or submission of insurance forms.

Excluded code:

99080

k) Additional exclusions are listed under sections 4.5.01 through 4.5.12 of the waiver document.

3.10.3 The PCN scope of service provided to the new waiver eligible adults with earnings up to 150 percent of the federal poverty level, identified in the T&C as "Demonstration Population I" is hereunder listed.

General Policy. The Primary Care Network serves a population not previously eligible for Medicaid. The scope of service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. Services in the office should comport with the definition of primary care found in Utah Code Annotated 26-18-301(2)(3):

"(2) 'Primary health care' means:

(a) Basic and general health care services given when a person seeks assistance to screen for or to prevent illness and disease, or for simple and common illnesses and injuries; and

(b) Care given for the management of chronic diseases.

(3) 'Primary health care services' include, but are not limited to:

(a) Services of physicians, all nurses, physician's assistants, and dentists licensed to practice in this state under Title 58;

(b) Diagnostic and radiologic services;

(c) Preventive health services including, but not limited to, perinatal services, well-child services, and other services that seek to prevent disease or its consequences;

(d) Emergency medical services;

(e) Preventive dental services; and

(f) Pharmaceutical services. "

3.10.3.1*Physician Services*

Physician services provide for the basic medical needs of eligible individuals and must be provided within the parameters of accepted medical practice. Services are to be provided by primary care specialists such as those practitioners licensed in family, internal, pediatric, obstetrics/gynecology, or general practice medicine, in addition to FQHCs, local health clinics (LHC), UMAP clinics, and tribal and IHC clinics.

Physician services may be provided directly by the physician or by other professionals—nurse practitioners, nurse mid-wives, or physician assistants—authorized to serve the health care needs of the practice population through an approved scope of

service under the physician's supervision.

Physician assistants work under the supervision of a physician to provide service to patients within the practice population.

Certified family or pediatric nurse practitioners are limited, under their scope of practice, to a cooperative, ambulatory, office type, working relationship with a physician. When employed by the physician, the physician bills for the service.

Certified Registered Nurse Midwives (CNMs) practice with relative independence under their scope of service and in association with obstetrician/gynecologists or other physicians from whom they can seek consultation, or refer high risk patients when necessary. CNMs practice under a Medicaid scope of service, including unique codes, approved for their specialty.

Physician services includes minor surgery and anesthesia that can be performed in an outpatient setting.

The ***CPT Manual*** is the standard for defining and coding physician services. Under the provisions of the PCN plan, not all procedures are acceptable, e.g., experimental, cosmetic, or those not reasonable and necessary or cost effective. Nonspecific or unlisted codes require physician review because of the potential for use to cover otherwise non-covered services.

The *Medicaid Medical and Surgical Procedures List* will be used with this program. This list serves as a guide as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic, or not reasonable and necessary. The list could apply to either office service or to minor surgical procedures which are possible under this plan.

The CPT office visit, evaluation and management codes (99201

through 99215) for either new or established patients are appropriate for the office services claims under this plan.

In general, both office visit and service codes will not pay for same date of service.

A supplemental list of codes not addressed in the main list has been developed for inclusion under this plan (Attachment G).

3.10.3.2*Lab and Radiology Services*

Professional and Technical laboratory and radiology services are furnished by certified providers with use of the 70000 and 80000 series of codes.

a) Laboratory services are limited under federal CLIA regulations. All laboratory testing sites providing services must have either a CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Only laboratories CLIA certified can complete certain tests and receive payment.

b) Federal regulation has identified the CLIA limited procedures as well as those tests (approximately 8 tests) and test kits (approximately 50) that can be used by physicians in the office to provide service.

c) Some laboratory and radiology procedures are non-covered and listed on the *Medicaid Medical and Surgical Procedures List* because they relate to otherwise non-covered services. This is consistent with exclusions under Section 4.5.05 of the waiver

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3.10.3.3*Durable Medical Equipment and Supplies*

Equipment and appliances necessary to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment, may be provided. However, the waiver notes that "The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion."

The following codes represent covered equipment and supplies under the PCN Plan:

A4460; A4565; A4927; A4490 through A4510; A4253; E0114; E0135 LR; A4570; A4614; Y6050 LR; K0001 LR and L0120.

3.10.3.4*Preventive Services and Health Education*

The PCN plan includes preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management.

These services are assumed under the general evaluation and management care provided to patients by the physician during medical visits. The services include counseling, anticipatory guidance, and/or risk factor reduction interventions. Limited special programs are covered.

Immunization codes are available:

Administration fee: 90471 through 90474
Specific immunization agent: 90476 through 90749

3.10.3.5*Family Planning Services*

These services includes disseminating information, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. All services must be provided or authorized by a physician, certified nurse midwife, or nurse practitioner, and must be provided in concert with Utah law. See non-covered section 3.10.3.14(i) below.

3.10.3.6*Hospital Services: Emergency Only*

The plan for PCN enrollees does not cover inpatient or outpatient hospital services except for emergency services in a designated hospital emergency department.

Revenue codes and ICD.9.CM diagnosis codes are the main means of documentation for these services.

Revenue codes appropriate to be covered for emergency service are:

Emergency Room: 450; 458 and 459
Laboratory: 300; 302; 305; 306; 309; 925 and 929
Radiology: 320; 324 and 329
EKG/ECG: 730 and 739
Respiratory therapy services: 410
Inhalation therapy services: 412 and 419
Cast room: 700 and 709
Observation/treatment room: 760 through 762 and 769
Pharmacy (medications for use in ED): 250; 260 and 269
IV Solutions: 258
Medical/surgical supplies (use in ED only): 270

All other Revenue codes on the list would be non-covered under this plan.

In addition, the current *Medicaid Authorized Diagnoses List for Emergency Department Reimbursement* is incorporated as approved emergency department care. Any code other than those listed would be a non-covered service resulting in decreased payment. The diagnoses in the *Authorized Emergency Department List* are ICD.9.CM codes.

Note: Section 4.4.01 of the Waiver has the statement that physician services "includes minor surgery and anesthesia that can be performed in an outpatient setting." The *Medicaid Medical and Surgical Procedures List* is very comprehensive in listing excluded codes or non-covered services. However, procedures appropriate for outpatient surgery have never been identified by Medicaid. Outpatient surgery coverage for this plan should be limited to those procedures that are very minor, superficial or uncomplicated---10021 through 12057 for skin, subcutaneous, and accessory structures, and 16000 through 16036 for local treatment of burns. Beyond this point, the procedures become more complicated and would require more extensive or complicated intervention requiring case by case review for coverage.

3.10.3.7*Pharmacy Services*

The Medicaid Pharmacy Policy as set forth in the *Pharmacy Manual for Utah Medicaid* clients is hereby adopted for the PCN group of clients with the following changes. Coverage is more restrictive for units. There will be no conflict with Section 1927 of the Social Security Act under this program. There will be a preferred drug list which is permissible under OBRA 90.

Pharmacy services include most, but not all, prescribed drugs and preparations provided by a licensed pharmacy. The fact that a provider may prescribe, order, or approve a prescription

drug service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. A select list of OTC drugs is covered.

3.10.3.7.1*Drug Limitations:*

a) This program is limited to four prescriptions per month, per client with no overrides or exceptions in the number of prescriptions.

b) The co-pay is $5.00 per generic product prescription.

c) When a generic equivalent is not available, the co-pay for the name brand is 25% of the EAC for the product.

d) When a generic equivalent is available and the name brand is requested the total payment must be made by the client.

e) A patient paid prescription is not counted as one of the four per month limit.

f) Prior approval and the criteria governing such are the same as the regular Medicaid program. The following drugs requiring prior approval:

Aciphex	Normiflo
Adagen	Oxandrin
Aggrenox	Panretin topical gel
All growth hormones	Prevacid
Anphetamines	Prilosec
Anzemet	Prolastin
Cerezyme	Protonix
Darvocet, Darvon	Regranex

Enbrel	Relenza
Fragmin	Retin-A gel
Kytril	Ritalin/Methylphenidate
Lactulose syrup	Tamiflu
Lovenox	Xenical
Lufyllin	Zofran

g) Generic drugs with an A B rating are mandated for dispensing unless the client pays the total prescription outside of this Medicaid program, or unless there is no generic and the name brand is medically necessary and 25% of EAC co-pay is made.

h) Name brand drugs where generics are available will require full payment by the client; no physician DAW is available.

i) Over-the-counter products are on the attached list. The extent of these products is more limited than regular Medicaid.

3.10.3.7.2*Pharmacy Exclusions*:

a) No duplicate prescription will be paid by Medicaid for lost, stolen, spilled or otherwise non usable medications unless counted as an additional prescription.

b) No injectable products are available for payment by Medicaid except for 10 ml vials of Insulin.

c) Compounded prescriptions are not covered.

d) Drugs are covered for labeled indications only.

e) Rapidly dissolving tablets, lozenges', suckers, pellets,

patches, or other unique formulations or delivery methodologies are not available. Patches are not reimbursable.

f) Therapeutic duplications are not available except by action from the DUR Board.

g) Cosmetics, weight gain or loss products are not covered.

h) No vitamins or minerals except for pregnant women are covered.

Cumulative monthly amounts are for the following drugs.

i. Stadol NS - 5
ii. Ultram/Ultracet - 90
iii. Tryptans (for migraine headache) - 9
iv. Carisoprodol (Soma) - 60
v. Narcotic/APAP - 120
vi. Oxycontin - 120
vii. Preven - 2
viii. Cox-2 agents - 33
ix. PPIs - 31 with prior approval for override.

3.10.3.8*Dental Services*

Limited scope of service: Exams, preventive services, fillings, and limited extractions.

3.10.3.9*Hearing Services*

Audiology services were eliminated by the 2002 legislature. Waiver amendment to follow

3.10.3.10*Vision Care*

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice. Services include:

Eye refractions/examinations – no glasses
One examination every 12 months

The following codes are covered:

92002; 92012 and 92015

3.10.3.11*Transportation Services*

Ambulance (ground and air) service for medical emergencies only.

The following codes are covered:

A0425 and A0429 through A031.

3.10.3.12*Interpretive Services*

Interpretive/medical translation services will be provided by entities under contract to Medicaid for people with limited English proficiency and for the deaf.

No specific codes are identified. When providers use the Medicaid authorized interpretive services, payment is made to the entity under terms of the signed contract. Medical providers may use their own interpreters. However, independent interpreters cannot bill nor be paid by Medicaid. Payment remains the responsibility of the provider who secured their services.

3.10.3.13*Limitations*

a) The ***CPT Manual*** is the standard for defining and coding physician services. However, not all procedures are covered under the plan, e.g., experimental, ineffective, cosmetic, or those non-cost effective, reasonable or necessary.

b) Use of non-specific or unlisted codes to cover procedures not otherwise listed in the ***CPT Manual*** require physician review and approval because of the potential for use to cover otherwise non-covered services.

c) Limitations on physician services and medical visit exclusions listed under Section 4.4.04 of the Waiver are identified in the *Medicaid Medical and Surgical Procedures List*. Implementation of this list will provide appropriate edits.

d) Evaluation/management office visit codes (CPT) for new and established patients (99201 - 99215) must be used appropriately on claims for service.

e) Office visit codes (E/M 99201 through 99215) and service codes 10060 through 69990 and 90780 through 99199 will not be paid on the same date of service.

f) After-hours office visit codes cannot be used in a hospital setting, including emergency department by private or staff physicians. They cannot be used for standby for surgery, delivery, or other similar circumstances, and they cannot be used when seeing a new patient.

g) Subsequent hospital care codes 99231 through 99233 should not be billed following any surgical procedure. Surgical procedures are covered by a global fee.

h) Cognitive services are limited to one service per day by the same provider.

i) Office or hospital visits one day prior or the same day as a surgical procedure are considered part of the global surgical procedure and paid accordingly.

j) Substance abuse and dependency treatment is limited to specific provider groups with some service limitations.

k) Modifier 25 will not be recognized as a stand alone entity to override the one service per day limitation.

l) Laboratory services provided by a physician in his office are limited to the approved kits, waived tests or those laboratory tests identified by CMS for which each individual physician is CLIA certified to provide.

m) A specimen collection fee is limited only to specimens drawn under the supervision of a physician to be sent outside of the office for processing.

n) Finger, heel, or ear sticks for blood analysis are limited only to infants.

o) Anesthesia services are limited to those provided directly to a patient in conjunction with authorized, covered surgical services. Monitored or standby service is not covered.

3.10.3.14*Non-Covered Services*

a) Inpatient or outpatient hospital diagnostic, therapeutic, or surgical services, except for those in the emergency department or those very minor procedures which can be provided outpatient.

b) Procedures that are cosmetic, experimental, investigational, ineffective or not within the limits of accepted medical practice.

c) Health screenings or services to rule out familial diseases or conditions without manifest symptoms.

d) Charges incurred as an organ or tissue donor.

e) Routine drug screening.

f) Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, or for insurance or employment examinations.

g) Non-emergency ambulance service through common or private aviation services.

h) Transportation service for the convenience of the patient or family.

i) Services excluded as family planning services:

Norplant: 11975, 11976, 11977.

Infertility studies and reversal of sterilization: ICD.9.CM diagnosis codes:

Male—606.0 through 606.96 and CPT Procedure Codes: 54240; 54250; 54900; 54901; 55200; 55300 and 55400.

Female—256.0 through 256.9; 628.0 through 628.9 and CPT Procedure Codes: 58345; 58350; 58750; 58752; 58760 and 58770

Assisted Reproductive Technologies (ART's) (in-Vitro): ICD.9.CM diagnosis code: V26.1 and above infertility diagnosis codes; ICD.9.CM procedure codes: 66.1; 66.8; 69.92; 87.82, 87.83; CPT procedure codes: 58321 through 58323; 58970; 58974; 58976; 89250 through 89261; 89264 and 89321.

Genetic Counseling: ICD.9.CM diagnosis code: V26.3, V65.40, V25.09; CPT Procedure codes for cytogenetic studies: 88230 through 88299. (Genetic counseling is being covered to some extent by Medicaid through laboratory tests, counseling under office calls, and other sources that cannot be identified.)

j) Chiropractic services
k) Podiatry services
l) End-stage renal disease (dialysis)
m) Medical and surgical services of a dentist
n) Organ transplant services
o) Abortion
p) Sterilization
q) High-risk pregnancy services
r) prenatal initiative program
s) Mental health and substance abuse service
t) Long-term care
u) Home and Community Based Waiver services
v) Targeted case management
w) CHEC enrollees/services
x) Home health and hospice services. This exclusion applies regardless of whether services are recommended by a

provider and include the following:

i. skilled nursing service;
ii. supportive maintenance;
iii. private duty nursing;
iv. home health aide;
v. custodial care;
vi. respite care; and
vii. travel or transportation expenses, escort services, or food service.

y) Other outside medical services in free standing centers

z) Additional exclusions are listed under sections 4.5.04 through 4.5.12 of the waiver document.

3.10.3.15PCN Coding

Covered CPT codes which could be provided as part of an office service are difficult to identify. The office visit/evaluation and management codes 99201 - 99215 would be the major codes used. Services in the office should comport with the definition of primary care found in Utah Code Annotated 26-18-301(2)(3) [See 3.10.3]. Very few surgical procedures would be or should be appropriate for office service. And, in general, both office visit and service codes should not pay for same date of service.

The *Medicaid Medical and Surgical Procedures List* is fairly comprehensive in listing excluded codes or non-covered services. However the list does not begin at the beginning of the ***CPT Manual***. Only those procedures that are very minor, superficial or uncomplicated should be provided under this plan.

The following is a review of the CPT codes not addressed on the

List:

10021 and 10022 (fine needle aspiration) should be excluded as office service.
10040 (acne surgery non-covered cosmetic)
10060 and 10061, and 10080 (incision and drainage of an abscess) could be covered if minor
10081 (complicated) non-covered as office service
10120 (removal of foreign body—subcutaneous -could be covered if minor)
10121 (complicated non-covered)
10140 and 10160 (drainage of hematoma or abscess) could be covered if minor.
10180 (post operative wound infection) non-covered
11000 through 11044 (debridement of skin or wounds non-covered)
11055 through 11057 (paring or cutting of toe nails non-covered
11100 and 11101 (biopsy skin non-covered)
11200 and11201 (removal of skin tags—cosmetic non-covered)

There is new policy going out in the April bulletin. The following two groups of codes are cosmetic (benign skin lesions) and must follow Criteria #34 on the *Medicaid Medical and Surgical Procedures List:*

11300 through 11313 and 11400 through 11446
11450 through 11471 (cosmetic non-covered)
11600 through11646 (excision of malignant lesions, probably not appropriate for office service.)
11719 through 11772 (nail services non-covered.)
11900 and 11901 (injection of lesions—undefined non-covered)
12001 through 12021 simple wound repair may be appropriate for office service.

From this point on, procedures are addressed on the *Medicaid*

Medical and Surgical Procedures List, and become more complex and not suited for office service. However, some of them may be found on the emergency room list as appropriate emergency procedures.

Codes beyond 20000 through 69979 would either be emergency room service or operating room service which will be excluded from coverage for this group.

3.11 Coverage Vehicles

3.11.1 Managed Care Networks. Individuals living in the four Wasatch Front counties[5] who become eligible for Medicaid and are not institutionalized, are required to select an HMO to receive medical care. In three additional counties, one contracting HMO is an option for Medicaid eligibles, or they may elect to receive benefits on a fee-for-service basis

3.11.1.1 HMOs. The state contracts with four managed care plans to provide services to Medicaid enrollees. Each of the plans offer services in at least three of the four Wasatch Front counties, providing a choice of plans for consumers. Three of the four also have one or more commercial product and the fourth is a public program only plan, offering only a Medicaid and CHIP product. This HMO also offers services in three additional counties. Each of the four are network-based plans with a mix of paying providers under fee-for-service or risk-based arrangements. None are staff model.

3.11.1.2 The division's MCO contracts detail MCO qualifications and responsibilities. The decision to contract with an MCO is largely based on that organization's ability to meet division-defined contract requirements concerning:

[5]Davis, Salt lake, Utah, and Weber counties representing approximately 70% of the state population.

a) access, member services and utilization;
b) quality; and
c) financial stability.

These requirements define what MCOs must provide to Utah Medicaid members enrolled in the plan, and are the cornerstone of all contract management activities. The division requires that each MCO:

a) provide services consistent with generally accepted standards;

b) address the specific needs of the Utah Medicaid population;

c) use best practice standards and be improvement-oriented; and

d) work with the division to identify and implement improvement strategies.

In addition, the division sets requirements around cultural competency, and requires that the MCO incorporate in its policies, administration, and delivery of services the values of honoring the enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and providers which respect the enrollees' cultural backgrounds. The MCO must foster cultural competency among its providers. Culturally competent care is care given by a provider who can communicate with the enrollee and provide care with sensitivity, understanding, and respect for the enrollee's culture, background and beliefs. The MCO is required to

ensure its providers provide culturally sensitive services to the enrollees. These services shall include but are not limited to providing training to providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to health care services.

3.11.1.3 The division pays the HMOs a monthly capitation rate on a per-member per-month basis, based on a member's eligibility category, age and in some cases gender. Capitation rates are developed commensurate with the risk facing an MCO. Utah currently uses twelve different rate cells. Rates for each cell were originally determined based on the historical cost to provide services to the group and have been adjusted for inflation and program changes.

Utah has used the Chronic Illness Disability Payment System (CDPS) to adjust rates to reflect the risk mix in for each plan. In addition, the division shares risk with plans through a stop-loss provision in the managed care contracts. When HMO costs exceed $50,000 in a fiscal year, the division reviews those expenditures and shares the risk for all costs above the $50,000 level on an 80/20% split.

Rate cells for the Non-Traditional Medicaid population will be developed to reflect the more restricted scope of services.

3.11.1.4 Prepaid Mental Health Plans (PMHP). Utah contracts with community mental health centers for mental/behavioral health services. These pre-paid plans cover all but one county in the state. The PMHPs are generally staff models, though each contract with providers in a fee-for-service

arrangements when consumers have needs which cannot be met by providers employed by the community mental health center.

The division pays PMHPs a monthly capitation rate on a per-member per-month basis, based on a member's eligibility category, age and in some cases gender. Capitation rates were developed based on the historical costs to provide services to the group and have been adjusted for inflation and program changes.

Rate cells for the Non-Traditional Medicaid population will be developed to reflect the more restricted scope of services.

3.11.2Traditional Medicaid. Enrollees in Utah's Traditional Medicaid product will continue to receive services as they have prior to implementation of the 1115 waiver. Those living in mandatory HMO counties will select an HMO from those contracting to provide services in the specific county. Those living outside the mandatory counties will receive services under a fee-for-service arrangement or, when available, have the option of enrolling in an HMO. These enrollees will continue to receive mental/behavioral health services through the PMHPs, except for those living in San Juan County. Those individuals will continue to receive services on a fee-for-service basis.

3.11.3Non-Traditional Medicaid. Enrollees in Utah's Non-Traditional Medicaid product will receive services through the same service delivery vehicle as the Traditional Medicaid enrollees. Those living in mandatory HMO counties will select an HMO from those contracting to provide services in the specific county. Those living outside the mandatory counties will receive services under a fee for service arrangement or, when available, have the option of enrolling in an HMO. These enrollees will continue to receive

mental/ behavioral health services through the Pre-paid Mental Health Plans, except for those living in San Juan County. Those individuals will continue to receive services on a fee for service basis. They will receive a reduced package of benefits from that which the Traditional Medicaid enrollees receive.

3.11.4Primary Care Network Plan: Primary care as defined in section 3.10.3 above will be provided to PCN eligibles by physicians with a specialty in primary care. The division will continue to use the former Medicaid UMAP clinics, FQHCs, LHCs, and private practitioners for the provision of primary care to PCN enrollees.

The state currently has no adequate tracking mechanism to ensure an adequate capacity for serving the new PCN population, although the state does not anticipate a problem of this nature. The department will attempt to identify a reliable means for accomplishing it, and accepts, at the outset, the recommendation of CMS to use complaint tracking as one tool. As a beginning, the state will:

a. send a letter to all providers currently enrolled as Medicaid providers in Utah asking them to indicate the level of interest in the PCN program;

b. use existing constituent service and complaint systems to monitor complaints about capacity in the PCN, if any, on a quarterly basis by the BES Customer Service Coordinator;

c. periodically check with community health centers and the Utah Health Clinics for indications that these health clinics are over used; and

d. ask for information about this issue from provider groups

and advocacy groups.

FQHCs and LHCs will be reimbursed on the fee-for-service method based on an enhanced rate of payment (Medicaid rate plus 10%) just as will all other providers.
IHS and tribal clinics will be eligible to serve as PCN clinics. The state will claim 100% reimbursement from IHS whenever appropriate.

Enrollees in Utah's Primary Care Network will receive services outlined on a fee-for-service basis from providers currently contracting with Medicaid. The focus on primary and preventive care will result in payment to providers who traditionally give primary and preventive care.

Specialty care will not be paid and will only be available to individuals through providers who volunteer their services. Covered services, and the providers who may give them, as well as limitations and exclusions are listed under section 4.5 of the waiver document and 3.10.3 of this document.

3.11.5The group referred to in the *Terms & Conditions* as demonstration population II—high-risk pregnant women—will be served using the HMOs under contract with the division in the urban areas, and on a fee-for-service basis in rural areas not covered by managed care contracts.

3.11.6Employer Sponsored Insurance. Currently, there are no available employer sponsored plans similar to the PCN. However, HB 122, passed by the 2002 legislature provides the authority to the department, the Insurance Commissioner, and private employers to proceed in developing private employer coverage similar to the PCN. A waiver amendment will follow to address this area. See Attachment H.

3.12 Cost-Sharing

The cost-sharing exemptions contained in 42 CFR 447.53, i.e., for pregnancy-related services, institutionalized individuals, emergency services, and family planning will fully apply under the demonstration project for the Non-Traditional Medicaid group, and, when applicable, to the PCN group..

3.12.1 Non-Traditional Medicaid:

a) Hospital services—Inpatient services require a $220 co-insurance for each inpatient admission.

b) Non-emergency use of emergency services—requires a $6.00 co-payment for each non-emergent visit.

c) Outpatient office visits—requires a $3.00 co-pay for each visit for physician and physician-related services, mental health services, and physical therapy visits. No co-payment is required for preventive services or immunizations.

d) Prescription drugs—requires a $2.00 co-payment for each prescription.

e) Vision screening services—up to $30 allowed. Any amount above $30 is not covered.

f) Out-of-pocket maximum is $500 calendar year per enrollee.

3.12.2 PCN:

a) Hospital services—there is no inpatient hospital coverage for the PCN.

b) Emergency services—each emergency room visit requires a $30 co-pay.

c) Outpatient office visits—requires a $5.00 co-pay for each visit for physician and physician-related services. There is no co-pay for preventative services and immunizations.

d) Laboratory and X-Ray services.

i. Laboratory under $50 requires no co-payment or co-insurance.
ii. Laboratory over $50 requires co-insurance of 5% of allowed amount.
iii. X-Ray services under $100 requires no co-payment or co-insurance.
iv. X-ray services over $100 requires co-insurance of 5% of allowed amount.

e) Prescription drugs—requires a $5.00 co-pay on generic and brand name drugs on formulary, and 25% of allowed amount for brand names not on approved list. No groups are excluded.

f) Durable medical equipment—requires co-insurance of 10% of allowed amount.

g) Dental services—Limited scope of service: Exams, Preventive services, Fillings, and Limited extractions.—10% of allowed amount.

h) Out-of-pocket maximum is $1000 calendar year per enrollee.

i) Tribal members—when using the IHS or tribal health care system—will not be required to pay co-payments, co-insurance, or deductibles. PCN eligibles holding a tribal membership card, or otherwise documented as a tribal member, and residing in the following Utah counties will be exempt from all cost-sharing provisions:

Beaver	Kane
Box Elder	Millard
Carbon	Piute
Duchesne	San Juan

Emery	Tooele
Grand	Uinta
Iron	Washington
Juab	

3.12.3 Demonstration Population II: Cost sharing is limited to that described in Utah's current Medicaid State Plan.

The division will use the current processes and controls that it uses for its traditional Medicaid population to monitor compliance with the cost sharing limits in the state plan for demonstration II eligibles.

3.13 Quality Assurance

The approach of The DHCF to quality monitoring focuses on continuous quality improvement. The purpose of the quality monitoring process is to assure that clients have access to quality care. The methods of monitoring quality of care and service delivery are divided into three sub-parts based on the type of delivery system: the Prepaid Mental Health Plans, the HMOs, and fee-for-service.

3.13.1 Prepaid Mental Health Plan (PMHP): Non-Traditional Medicaid clients enrolled in PMHPs.

3.13.1.1 Onsite Quality Assurance Monitoring. The DHCF will implement its onsite quality assurance monitoring plan for all Medicaid clients enrolled in the PMHP. Elements of quality monitoring (QM) applicable to the Non-Traditional group will be integrated into the existing QM program.

3.13.1.2 Clinical Quality Reviews. A component of the DHCF's monitoring plan includes clinical quality reviews that will include a review of the quality and appropriateness of services provided to the Non-Traditional group.

3.13.1.3Review of PMHP Complaints. Another component of the monitoring plan includes a review of Medicaid clients' verbal and written complaints received by the PMHP contractors. PMHPs will separately track complaints from the Non-Traditional group.

3.13.1.4Complaints Received by the DHCF. Complaints received by the DHCF from Medicaid clients that are indicators of access and quality will be tracked and reviewed separately for the Non-Traditional group and for the PCN group. The state will also use complaints as an indicator of provider capacity for the PCN.

3.13.1.5Periodic Consumer Surveys. Surveys designed to find out what PMHP clients think about their experience with the PMHP will be conducted periodically. Questions related to quality will be included; e.g., how do you rate services received, are you receiving care that you need and as soon as you need it, etc. Survey results for the Non-Traditional Medicaid group will be analyzed separately.

3.13.1.6Fraud Monitoring. PMHPs must have a compliance plan that outlines their internal processes for identifying fraud and abuse. The PMHPs must refer in writing to The DHCF all detected incidents of potential fraud or abuse on the part of providers of services to enrollees or other patients. The Project Integrity Unit (PIU) in the DHCF reviews fraud and abuse referrals to determine if a problem exists; if it will be handled through education or through overpayment collection. If a trend is encountered, the unit, in conjunction with the division director, determines if there appears to be intent, mis-communication, etc. If it appears to be a situation that should be handled by a civil process the division assistant director will coordinate investigative activities. If it is determined that the problem is a trend with apparent intent to fraud, the case is

referred to the Medicaid Fraud Control Unit.

3.13.1.7 Corrective Action Plans. The DHCF will require PMHPs to develop corrective action plans when quality issues are identified through any of the above methods.

3.13.2 HMO: Non-Traditional Medicaid clients enrolled in HMOs

3.13.2.1 Onsite Quality Assurance Monitoring. The DHCF will implement its onsite quality assurance monitoring plan for all Medicaid clients enrolled in HMOs. Elements of quality monitoring applicable to the Non-Traditional group will be integrated into the existing QM program.

3.13.2.2 Clinical Quality Reviews. A component of the DHCF's monitoring plan includes clinical quality reviews that will include a review of the quality and appropriateness of services provided to the Non-Traditional group. Another component of the monitoring plan is the review of quality studies performed by HMOs that measure clinical outcomes, service utilization, and health care costs. During the review of these studies, care provided to the Non-Traditional group will be evaluated, areas for improvement will be identified and recommendations for improvement will be addressed with HMOs.

3.13.2.3 Review of HMO Complaints. Another component of the monitoring plan includes a review of Medicaid clients' verbal and written complaints received by HMO contractors. HMOs will separately track complaints from the Non-Traditional group.

3.13.2.4 Complaints Received by the DHCF. Complaints received by the DHCF from Medicaid clients that are indicators of access and quality will be tracked and reviewed separately for the Non-

Traditional group.

3.13.2.5Tracking HMO Changes. The DHCF will track Non-Traditional HMO enrollees who change HMOs. The reason for switching will be linked to the client and the HMO. Reports will be produced that will help the DHCF analyze trends related to HMO changes. All quality of care deficiencies will be referred to a quality assurance nurse and will be tracked until resolved.

3.13.2.6HEDIS-Like Measures. Depending on the feasibility and availability of data, the DHCF could calculate HEDIS-like measures separately for this group using HMO encounter data.

3.13.2.7Periodic Consumer Surveys. Surveys designed to find out what HMO Medicaid clients think about their experience with HMOs will be conducted periodically. Questions related to quality will be included; e.g., how do you rate services received, are you receiving care that you need and as soon as you need it, etc. Survey results for the Non-Traditional Medicaid group will be analyzed separately.

3.13.2.8Fraud Monitoring. HMOs must have a compliance program to identify and refer suspected fraud and abuse activities. The compliance program must outline the HMO's internal processes for identifying fraud and abuse. HMOs must refer in writing to the DHCF all detected incidents of potential fraud or abuse on the part of providers of services to its enrollees or other patients. In addition, an HMO must inform in writing when a provider is removed from the HMO's panel for reasons related to suspected fraud, abuse or quality of care concerns. The PIU in the DHCF reviews fraud and abuse referrals to determine if a problem exists; if it will be handled through education or through overpayment collection. If a trend is encountered, the unit, in conjunction with the division

director, determines if there appears to be intent, mis-communication, etc. If it appears to be a situation that should be handled by a civil process the division assistant director will coordinate investigative activities. If it is determined that the problem is a trend with apparent intent to fraud, the case is referred to the Medicaid Fraud Control Unit.

3.13.2.9 Corrective Action Plans. The DHCF will require HMOs to develop corrective action plans when quality issues are identified through any of the above methods.

3.13.3 Fee-For-Service. Non-Traditional Medicaid group under FFS and all PCN eligibles

3.13.3.1 Post-payment Reviews of All Providers. The DHCF will periodically review an established minimum of active providers. On a quarterly basis, a sample of FFS providers will be reviewed in accordance with the objectives and criteria established within the review plan for that quarter. FFS providers will be grouped based on services provided to Non-Traditional versus PCN eligibles. Those providers exhibiting exceptional patterns of practice compared to his/her peers or identified through other processes will be reviewed by analyzing his/her claims history detail. Medical record documentation will be reviewed when necessary. Letters will be sent to providers identifying the apparent problem. Appropriateness of care issues will be presented to the DHCF utilization review panel for its review and closure or referral to another agency.

3.13.3.2 Complaint Monitoring System. The DHCF will maintain a compliant monitoring system that will be used to track all quality of care issues received by the division. Quality of care issues will be referred to the appropriate program manager who will consult

a registered nurse, physician or other medical professional, as necessary. Claims history details will be analyzed when necessary. On a quarterly basis, notices are sent to a sample of clients requesting that clients confirm all services—as indicated in the MMIS—have been provided to the client. When clients include a quality of care complaint, it will be tracked through to resolution.

3.13.3.3Periodic Consumer Surveys. Surveys designed to find out what Medicaid clients think about their experience under the PCN program will be conducted periodically. Questions related to quality will be included; e.g., how do you rate services received, are you receiving care that you need and as soon as you need it, etc. Comparative analyses could be conducted to evaluate the need for improvement in certain geographical areas. Focused groups of FFS clients surveyed could be conducted.

3.13.3.4HEDIS-Like Measures. Depending on the feasibility and availability of data, the DHCF could calculate HEDIS-like measures for the FFS populations.

3.13.3.5Fraud Control Monitoring. The PIU in the DHCF reviews fraud and abuse referrals to determine if a problem exists; if it will be handled through education or through overpayment collection. If a trend is encountered, the unit, in conjunction with the division director, determines if there appears to be intent, mis-communication, etc. If it appears to be a situation that should be handled by a civil process the division assistant director will coordinate investigative activities. If it is determined that the problem is a trend with apparent intent to fraud, the case is referred to the Medicaid Fraud Control Unit.

3.14 Grievances and Appeals

The Medicaid agency has a system of administrative hearings for medical providers and dissatisfied applicants, clients, and recipients that meets all the requirements of 42 CFR Part 431, Subpart E.

A client or provider may request an agency conference or formal hearing if dissatisfied with any decision made by the DHCF. A formal hearing before the Department of Health may be requested within 30 days of the date of the agency action. The request for the agency conference and/or formal hearing must be in writing and sent to:

DIVISION OF HEALTH CARE FINANCING
DIRECTOR'S OFFICE/FORMAL HEARINGS
BOX 143105
SALT LAKE CITY UT 84114-3105

or FAX it to: (801) 538-6478

All administrative hearings will be conducted in accordance with Utah Administrative Rule R410-14 Administrative Hearing Procedures. Rule R414-1-11 will also be applied. Please see Attachment I for copy of the Utah Administrative Rule.

3.15 Evaluation Design

Program evaluation is useful not only in assessing the outcomes of a project or program being evaluated, but also necessary for finding ways of improving the program. The Utah Department of Health is vitally interested in the evaluation process and its outcomes, as it believes that the information derived will immensely benefit the state's continuing efforts in health care reform. It will also provide information useful to other states as they embark upon health care reform.

There will be two types of evaluation executed for the PCN demonstration project: first, a formative evaluation to chart the progress of the demonstration and to assist in identifying and correcting problem areas, in addition to

monitoring such budgetary concerns as cost neutrality; and, second, a summative evaluation to demonstrate the effectiveness of the project and to answer the question of whether the project accomplished its goals within the budgetary constraints.

It is anticipated that CMS may contract with an outside party to conduct an additional summative evaluation as it does with most 1115 waiver demonstrations. In that case, the DHCF will participate in this evaluation in any context desired by CMS.

The Division of Health Care Finance in the Utah Department of Health will conduct the formative evaluation throughout the duration of the demonstration. This information will help to structure, guide and successfully implement the project. While there are differing definitions of *formative evaluation* in the literature, the division will define it as *process evaluation*, and may use the terms interchangeably. The evaluation process will be overseen by the Research and Evaluation Unit located in the Office of the Director, DHCF.

a. The division will collect and use empirical data to ascertain if the delivery of the program is meeting its objectives. In other words, to verify:

    1) what the program is that is being delivered;
    2) is it being delivered to the targeted audience as intended; and
    3) are the benefits and services being delivered those that were intended.

b. Since evaluation in this context will not require precise causal inferences necessitating comparative design, the state can develop such information through the data collection on appropriate process measures, and the state will be able to:

    1) obtain feedback on the quality of the ongoing delivery of the benefits under the PCN. In this way, the state can insure the highest degree of congruence between intention and delivery;

    2) determine who is receiving the benefits and services of the PCN to insure that the program is reaching the intended recipients; and determine

to what degree recipients in different regions of the state are receiving the benefits.

The demonstration will focus on three major hypotheses. Hypothesis one will be the proper focus of the formative evaluation.

3.15.1 Hypothesis One: Coverage of 9,000 single adults and 16,000 adults with children with limited primary care can be accomplished at no greater cost than the acute, chronic and specialty care for current UMAP clients.

Master Evaluation Criteria

a) Enrollment will accommodate no more that 9,000 single adults and no more than 16,000 adults with children.

b) Cost of claims will be equal to, or less than, an amount equal to current expenditures for UMAP, plus savings from reduced benefits for Non-Traditional eligibles, and required fees and cost sharing of the demonstration populations.

3.15.1.1 Hypothesis One Evaluation. There are concerns over the adequacy of PCN coverage meeting the health needs of the UMAP and new PCN eligible populations in terms of specialty care, and the challenges of recruiting volunteer specialists in this area. The division will conduct an on-going formative evaluation, beginning immediately with the collection of baseline data in at least 2 important areas:

a) donated, specialty care being received currently by UMAP clients; and

b) utilization patterns of the current 1931 TANF adults, medically needy and transitional Medicaid.

Some concern has been expressed over the effects of the PCN and its reimbursement rates on the FQHCs. Rather than being a focus in the on-going formative evaluation, an audit assignment will be made to determine the following:

a) utilization and reimbursement patterns of the FQHCs; and

b) impact on the ability of FQHCs to provide coverage for the uninsured.

The findings from the proposed baseline assessment will provide the PCN program timely and useful information to manage needed care for PCN enrollees. The baseline information will provide a benchmark for the program evaluation in the future.

The division will use the following business processes to structure its formative evaluation activities.

3.15.1.1.1Eligibility and Enrollment:

a) adults with children eligible;
b) single adults eligible; and
c) transitions to Traditional Medicaid.

3.15.1.1.1.1 Process Outputs:

a) number of adult parents enrolled;
b) number of UMAP transfers and single adults enrolled;
c) number of Transitional Medicaid eligibles enrolled;
d) number of non-eligibles transferred to Medicaid; and
e) number of non-eligibles denied.

3.15.1.1.1.2 Documentation Used:

a) monthly, quarterly and year-end counts of:

i. number of enrollees by program;
ii. number of enrollees by aid code;
iii. enrolled months;
iv. number disenrolled; and
v. number transitioned in to Traditional Medicaid.

3.15.1.1.2Enrollment Fees and Copay:

a) fees collected; and
b) cost shared contributions.

3.15.1.1.2.1 Process Outputs:

a) $50 annual fee—working; and
b) employer/other insured.

3.15.1.1.2.2 Documentation Used:

a) number - amount paid;
b) number - non-pay enrolled;
c) number non-pay not enrolled; and
d) number with other costs shared.

3.15.1.1.3Benefits and Scope of Service:

a) client information on

i. benefits;

ii. co-pay; and
iii. co-insurance;

b) out of scope appeals; and
c) client satisfaction.

3.15.1.1.3.1 Process Outputs:

a) benefits/cost share defined;
b) scope of coverage defined;
c) co-pay/co-insurance record;
d) appeals process defined; and
e) health status surveys.

3.15.1.1.3.2 Documentation Used:

a) number and distribution CPT in scope;
b) number and ratio of CPT out of scope;
c) disposition of specialty referrals;
d) number; costs recovered in co-pay;
e) number; costs not recovered;
f) number of appeals/reversals and ratio;
g) intake health status; and
h) periodic health status review.

3.15.1.1.4Provider Participation and Referral:

a) provider training;
b) statewide coverage; and
c) billing, payment and referrals.

3.15.1.1.4.1 Process Outputs:

a) providers identified;

b) number statewide, private, HIS, LHC, FQHCs;
c) training in billing, scope, co-pay, appeals, specialty referrals.

3.15.1.1.4.2 Documentation Used:

a) participating provider counts;
b) county distribution of providers;
c) training to providers;
d) claims activity by practice type;
e) illness/CPT activity type; and
f) referrals and acceptance tracking.

3.15.1.1.5Coverage Vehicles:

a) scope of services; and
b) out-scope referrals and cost share.

3.15.1.1.5.1 Process Outputs:

a) primary care inclusions;
b) co-pay and outscope coverage or referrals;
c) outscope transition/electives; and
d) emergency/hospital care.

3.15.1.1.5.2Documentation Used:

a) included services utilized—quarterly;
b) excluded services—quarterly;
c) transition for care—monthly;
d) co-pay/cost share included—quarterly;
e) cost share for referrals; and
f) other cost share monthly.

3.15.1.1.6Referral, Appeals and Quality:

a) referrals and transitions;
b) appeals and quality assurance;
c) out-scope acceptance; and
d) fraud control.

3.15.1.1.6.1Process Outputs:

a) specialty care referrals;
b) transitions to traditional/out
c) appeals and resolutions;
d) quality assurance management; and
e) fraud audit and tracking.

3.15.1.1.6.2Documentation Used:

a) services denied—monthly;
b) denials referred—monthly;
c) referrals accepted/denied quarterly;
d) appeals accepted/rejected;
e) number and costs for out of scope service; and
f) fraud review and processes.

3.15.1.1.7Benchmarks. will be established for each documentation criteria. The initial benchmarks will not be established as **desired** targets, but **only** as a beginning reference point for evaluation discussions that will be necessary for qualitative judgements and the establishment of reasonable benchmarks of success. For examples of such benchmarks, see Attachment J.

The DOH in-house summative evaluation will be conducted by the Office of Health Care Statistics and will be the focus for:

a. hypotheses two and three; and

b. the effect of the PCN on uncompensated care.

3.15.2 Hypothesis Two. The demonstration project will:

a) significantly reduce the number of Utahns without coverage for primary health care, and

b) lead to a general improvement in the overall well-being in the health status of PCN eligibles.

Master Evaluation Criteria. Criteria used to describe the results of Utah's on-going Health Status Survey, and the proposed longitudinal PCN individual well-being assessment survey being developed by the Department of Health, Office of Health Care Statistics.

3.15.2.1 Hypothesis Two Evaluation. Proofs for hypothesis number two will be more problematic and difficult to obtain; however, there are some suggested routes that the department will take in an attempt to accomplish the answers.

3.15.2.1.1 Health Status Survey. The DOH, Office of Public Health Assessment conducts the Utah Health Status Survey (UHHS) periodically. The 2001 UHHS survey will provide the baseline of the proportion of Utahns who are 19 and older, living under 150% federal poverty, and without coverage for primary health care (3.15.2 a). The next UHHS data collection will be conducted in 2003 and the PCN 3.15.2 a measure will be reported in 2004.

3.15.2.1.2 Longitudinal PCN individual well-being assessment survey. The DOH, OHCS and the Office of Children Access Initiatives will apply for funding to conduct three annual assessments of a sample of the PCN eligible and clients. The survey will focus on the following domains:

a) perceived health status (SF12);

b) employment status;
c) healthcare utilization pattern in the past 12 months (including inpatient hospitalization and emergency department visit);
d) specialty care utilization;
e) perceived healthcare needs;
f) risk factors/behavior (such as smoking);
g) previous enrollment in Medicaid or UMAP, if any; and
h) limited satisfaction with the last encounter with health care provider.

3.15.2.1.3 Methodology. The assessment tool will be a self-administrated mail survey questionnaire, supplemented by follow up telephone interviews. Three sources will be used to develop the questionnaire.

a) Utah Health Status Survey;
b) CDC Behavioral Risk Factor Surveillance Survey; and
c) NCQA Consumer Assessment of Health Plans Survey.

A baseline assessment will be taken by:

a) surveying 200 randomly selected PCN enrollees each month. The survey will be continued until receiving 2,500 completed questionnaires, or the cap of 25,000 enrollees is met (twelve to twenty-four month estimate.).

b) The survey method and protocol will be developed based on the NCQA CAHPS and CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) surveys' methods and protocols. It will have 3

mailings and 3 follow up telephone interviews for those who do not respond to the mail surveys.

c) The OHCS will analysis each month's sample and report to the PCN program on the preliminary information of the enrollees' health status and health care needs. The OHCS will analyze the three, six, twelve, eighteen, and twenty-four month samples to develop the baseline assessment.

Follow up surveys will take place in the 13th month after the survey is initiated. The method and protocol will be the same as the baseline survey.

3.15.2.1.4 Comparative Evaluation: If additional funding is available, the OHCS will conduct a PCN enrollee satisfaction survey Spring 2005, at the same time OHCS conducts the statewide adult CAHPS survey:

a) The general CAPHS adult survey will add a special module to address special issues PCN clients may be facing.

b) PCN enrollee surveys will occur as the state surveys other Medicaid and commercial HMO enrollees to provide comparative information for the PCN program management.

examples of the questions and formats, please refer to Attachment K.

3.15.3 Hypothesis Three: The PCN will significantly reduce the unnecessary visits to emergency departments by PCN enrollees.

3.15.3.1 Methodology. The OHCS will use PCN paid claims and the Emergency Department Use Classification, developed by Dr. John Billings at the New York University sponsored by the Robert Wood Johnson Foundation, as follows:

A. Emergency Status

1) Emergent -ED Care Needed - Not preventable/avoidable
2) Emergent - ED Care Needed - Preventable/avoidable
3) Emergent – Primary care treatable
4) Non – Emergent
5) Unclassified

B. Type of Visit

1) Mental health related
2) Alcohol related
3) Substance abuse related
4) Injury
5) Unclassified

OHCS will analyze the data every six months and provide feedback to the PCN program.

3.15.4 The effect of the PCN on hospital uncompensated care. The demonstration project will maintain the annual overall amount of Utah hospitals' reported uncompensated care, as of January 1 – December 31, 2001, controlling for inflation.

3.15.4.1. Definition of hospital uncompensated care: the sum of charity care and bad debt reported by Utah hospitals.

3.15.4.1.1 Data Sources:

a) Uncompensated care reported to the MedPac (OHCS is contacting the MedPac to obtain their permission to access the data at the hospital level. Result is unknown.)

b) Bad debt reported by the Medicare Cost Report (DOH has purchased the data.)

c) Charity care – DOH has no data on this issue. The Utah Hospital Association (UHA) has its member reported data on charity care. DOH is working with UHA to develop an evaluation plan for charity care.

3.15.4.2Office of Health Care Statistics will take the lead in the evaluation of uncompensated care and apply for funding to support the work.

3.16 Tribal Consultations

The Utah DOH established the Utah Indian Health Advisory Board (UIHAB) as a vehicle for tribal consultation. Each tribe has designated in a letter from their governing body, two individuals to represent them in discussions on health issues. The UIHAB meets the first Friday of each month. Tribal leaders are sent meeting notices and minutes in addition to the selected representatives.

The concept paper for the 1115 waiver was faxed to tribal leaders and health board members on August 28 with a notice of the agenda. The September 2001 agenda included a presentation by the Director of Health Care Financing on the 1115 waiver. Feedback was requested for the October meeting and Mr. Deily was again available for discussion. The minutes for these meetings reflect the discussion.

A copy of the waiver application was mailed to tribal leaders and UIAHB members on January 28, 2002. No written comments were received in response.

As implementation strategies were initiated, DOH decided to request the March UIHAB meeting be dedicated to assuring input on strategies. Given the legislative agenda, the meeting was moved from the first to the fifteenth. Meeting notices were sent out on January. A confirmation letter was sent March 4.

The consultation began at 8:30 a.m. on March 15. Minutes of the meeting reflect the statement that schedules would only allow a three-hour meeting on this day but further meetings would be scheduled as needed. Cost sharing was the issue of primary concern. The co-pay is being waived but not the enrollment fee of $50.00. This is viewed as a potential barrier to people accessing the program. The DOH requested the tribes present ideas on health behavior change strategies that would be appropriate in moving from urgent care to primary care philosophies. Further research is needed to determine if IHS can pay the enrollment fee. Additional meetings will be held in April to discuss data, media/marketing and off-reservation considerations. Minutes were recorded. Documentation of these efforts is presented in Attachment L.